

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05090

05084

1. PLACE OF DEATH a. COUNTY CARROLL				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FINKSBURG				c. LENGTH OF STAY IN TB 14 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE #2				d. STREET ADDRESS ROUTE #1			
3. NAME OF DECEASED (Type or print) CLAUDE COE ARMACOST				4. DATE OF DEATH Month APRIL Day 10 Year 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 1, 1896	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10		11. IF UNDER 24 HRS. Hours 10 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO., MD.	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME JOHN DANIEL ARMACOST				14. MOTHER'S MAIDEN NAME LILLIAN GERTRUDE CONSTANTINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-28-1055			
17. INFORMANT GEORGE ARMACOST				Address ROUTE #1 FINKSBURG MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <input checked="" type="checkbox"/> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 1966 to APRIL 1966 that (I) (we) last saw the deceased alive on APRIL 10, 1966 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Daniel J Welliver M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/66	
22c. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER				22d. ADDRESS 19 RIDGE RD WESTMINSTER, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/66		23c. NAME OF CEMETERY OR CREMATORY Finksbury Church Cemetery		23d. LOCATION (City, town or county) (State) Finksbury, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.				ADDRESS Westminster, Md.		25a. REC'D BY REGISTRAR APR 12 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 of the certificate should be retained by the hospital or attending physician.

TO FUNERAL HOME DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER MD.	
c. LENGTH OF STAY IN 1b 7 YRS.		d. STREET ADDRESS 56 CARROLL ST	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 56 CARROLL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE AGNES ARNOLD		4. DATE OF DEATH Month Day Year APRIL 27 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 14, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) WESTMINSTER, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. RICKLE		14. MOTHER'S MAIDEN NAME MARY E. HARMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-24-8076	
17. INFORMANT HUSBAND EBEN R. ARNOLD		Address 56 CARROLL ST. WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 1964, to April 27 , 1966, that (I) (we) last saw the deceased alive on April 26 , 1966, and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John S. Harshay		22b. DATE SIGNED 4/27/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHAY		22d. ADDRESS 8 ANCHOR ST. WESTMINSTER MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/30/66	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL		23d. LOCATION (City, town or county) (State) FINKSBURG, MD.	
24. FUNERAL DIRECTOR James C. Safford		25a. REC'D BY REGISTRAR APR 28 1966	
ADDRESS WESTMINSTER MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Union Bridge RD #1 c. LENGTH OF STAY IN 1b 50 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Union Bridge RD #1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle ELIZABETH Last BABYLON			4. DATE OF DEATH Month April Day 4 Year 1966				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1886		9. AGE (In years last birthday) 79 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co., Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME Joseph Warehime			14. MOTHER'S MAIDEN NAME Emma Bankert				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Noah H. Babylon		17. INFORMANT Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma - sigmoid. (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/20/66</u> 19 to <u>4/14/66</u> 19 , that (I) was saw the deceased alive on <u>4/11/66</u> 19 , and that death occurred at <u>3:30 P</u> PM , from the causes and on the date stated above.							
22a. SIGNATURE M.E. Robertson			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4/14/66		22c. PHYSICIAN'S NAME (Type) New Windsor, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/17/66		23c. NAME OF CEMETERY OR CREMATORY Baust Church Cemetery			
23d. LOCATION (City, town or county) (State) Union Bridge RD1 Md.		24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminister Md.					
25a. REC'D BY REGISTRAR APR 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>MAIN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKFIELD MANOR N. H.</u>							
3. NAME OF DECEASED (Type or print) <u>VIRGINIA MARIE BAILE</u>				4. DATE OF DEATH <u>APRIL 20 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 6 - 1884</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMPANION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FAMILY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>NATHAN H. BAILE</u>				14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-2083</u>		17. INFORMANT <u>H.P. BAILE NEW WINDSOR MD</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD</u> <u>4321</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. } DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1/52</u> 19 to <u>4/20/66</u> 19, that (I) (we) last saw the deceased alive on <u>4/20/66</u> 19, and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M.E. Robertson</u>				22b. DATE SIGNED <u>4/21/66</u>		22c. PHYSICIAN'S NAME (Type) <u>M.E. ROBERTSON</u>	
22d. ADDRESS <u>New Windsor, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-23-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER</u>		23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler</u>				25a. REGISTRY BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05094

CERTIFICATE OF DEATH

05092

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2926 Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL RODNEY BARBE		4. DATE OF DEATH Month Day Year APRIL 23 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1892
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. Frank Barbe		14. MOTHER'S MAIDEN NAME Mary Jane Nissberodt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes (Unk.)		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-14-66 , 19__, to 4-23-66 , 19__, that (I) (we) last saw the deceased alive on 4-23-66 , 19__, and that death occurred at 1:45 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 4-25-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-29-66	23c. NAME OF CEMETERY OR CREMATORY Stony Creek	23d. LOCATION (City or Town) (County) (State) Stony Creek Springs
24. FUNERAL DIRECTOR <i>Arthur H. Haight Sykesville, Md.</i>		25a. REC'D BY REGISTRAR APR 29 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b 20 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) School House Lane				d. STREET ADDRESS School House Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert W. Bean		4. DATE OF DEATH April 22 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 3, 1885		9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co., Md.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George T. Bean		14. MOTHER'S MAIDEN NAME Savilla Warfield		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Earl F. Mann		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Arteriosclerotic C.V. Disease		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1950 to April 22, 1966 that (I) (we) last saw the deceased alive on April 20, 1966 , and that death occurred at 8 PM from the causes and on the date stated above.		22a. SIGNATURE Martin E. Strobel		22b. DATE SIGNED 4-23-66		22c. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		22d. ADDRESS 18 Main St. Reisterstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/66		23c. NAME OF CEMETERY OR CREMATORY Deer Park Methodist Cem. Reisterstown, Md.		23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR APR 27 1966	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S NAME Westminster, Md.		25d. REGISTRAR'S ADDRESS		25e. REGISTRAR'S PHONE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05096

CERTIFICATE OF DEATH

05095

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a STATE Maryland b. COUNTY Frederick ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville		c. LENGTH OF STAY IN lb 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 151 W. All Saints St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS Frederick	
3 NAME OF DECEASED (Type or print) First Carrie Middle Amelia Last Bentley		4 DATE OF DEATH Month April Day 30 Year 1966	
5 SEX female	6. CO. OR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1880
9 AGE (In years last birthday) yrs 86	10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Bentley		14. MOTHER'S MAIDEN NAME Susan Skinner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Springfield Hospital Records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME WITH SENILE BRAIN DISEASE WITH PSYCHOTIC REACTION			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 4-22- 19 66 to 4/30/66 19 66 , that we (we) last saw the deceased alive on 4-30- 19 66 , and that death occurred at 12:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE R. G. Lejonchere MD M.D.		22b. DATE SIGNED 4/30/66	
22c. PHYSICIAN'S NAME (Type) R. G. Lejonchere - M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/66	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Frederick Frederick, Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 E. Hicks St. Frederick		25a. REC'D BY REGISTRAR MAY 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05097

CERTIFICATE OF DEATH

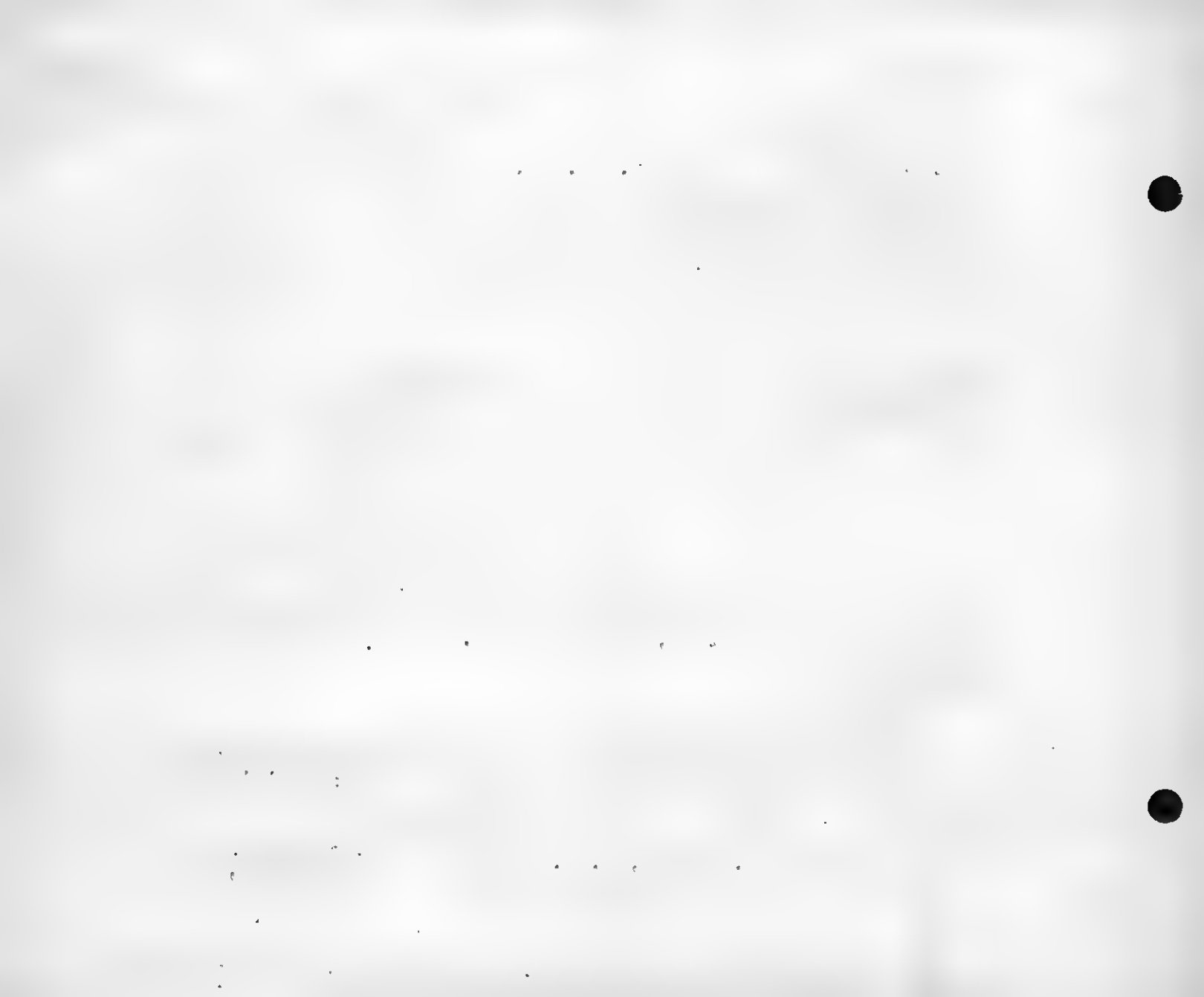
05091

1 PLACE OF DEATH a. COUNTY Garroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c LENGTH OF STAY IN 1b 38y. 5m. 4d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Springfield State Hospital		e STREET ADDRESS --	
3 NAME OF DECEASED (Type or print) First Roberta Middle ? Last Bishop		4 DATE OF DEATH Month 4 Day 11 Year 66	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/11/87
9 AGE (in years last birthday) yrs 78		IF UNDER 1 YEAR Months 4 Days 11	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bishop		14. MOTHER'S MAIDEN NAME Alice Besare	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO none	
17 INFORMANT Springfield Hospital records-Sykesville		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic congestive heart failure DUE TO (b) Mitral calcification and stenosis DUE TO (c) Chronic rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type.		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 10:40		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/77 , 19 27 , to 4/11 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/11 , 19 66 , and that death occurred at 10:40 p.m. from causes and on the date stated above.			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 4/11/66	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) 4-14-66		23b. DATE THEREOF SMITHSBURG	
23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG WASH MD		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Winnich Funeral Home Hagerstown		25a REC'D BY REGISTRAR APR 15 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66



05098

CERTIFICATE OF DEATH

05092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 10mos. 28dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2030 Edmondson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALEXANDER (NMN) BLACKWELL		4. DATE OF DEATH Month APRIL Day 19 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unk.
9. AGE (In years last birthday) 81?		10. IF UNDER 1 YEAR Months 19 Days 66 Hours 66 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY South Carolina	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Blackwell		14. MOTHER'S MAIDEN NAME Mary (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO 217-01-0670	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, without qualifying phrase			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-21-65 , to 4-19-66 , 19 4-19-66 , that (I) (we) last saw the deceased alive on 4-19-66 , and that death occurred at 5:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 4-20-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF 4-22-66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore md
24. FUNERAL DIRECTOR Russell B. Oden - Baltimore, md		25a. REC'D BY REGISTRAR APR 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05099

CERTIFICATE OF DEATH

05098

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yr 6mo 18da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1312 Dennis Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last James Meredith Blackwell		4. DATE OF DEATH Month Day Year April 16- 1966	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-78
9 AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min. 16- 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 223-03-6053	
17. INFORMANT Catherine		Address Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular disease 4221 DUE TO Beginning gangrene Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO Advanced Generalized Arteriosclerosis (c) Years		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis Chronic Brain Syndrome Associated with cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28-63 , 19__ to 4-16-66 , 19__, that (I) (we) last saw the deceased alive on 4-16-66 , 19__, and that death occurred at 8:45AM , from causes on the date stated above			
22a. SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 4-16-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, Md.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-17-66	
23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetery		23d. LOCATION (City or Town) (County) (State) Lexington VA	
24. FUNERAL DIRECTOR Harry W. Haight		25a. DATE BY REGISTRAR APR 19 1966	
ADDRESS Sykesville, Md		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05100
05099
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN b. <u>94m.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 WARD AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>21 WARD AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <u>MAZIE</u> First Middle Last (Type or print)			4. DATE OF DEATH <u>APRIL 3</u> 19 <u>66</u> Month Day Year				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 1894</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C.</u>	
13. FATHER'S NAME <u>Louis Kopp</u>			14. MOTHER'S MAIDEN NAME <u>Susanna Jacoby</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Artie K. Quayle</u> Address <u>3935 Mount Airy Baltimore 18, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>1201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>7 YEARS</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 MINUTES</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 1959</u> to <u>APRIL 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>APRIL 1, 1966</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William J. Stewart</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>-</u>			22d. ADDRESS <u>19 RIDGE RD. WESTMINSTER, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminister, Md.</u>			25a. REC'D BY REGISTRAR <u>APR 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

05101

CERTIFICATE OF DEATH

05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p>1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u> c. LENGTH OF STAY IN b. <u>9 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKFIELD MANOR N. H.</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>RURAL</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>ELEANORE LOGSDON BROWN</u> First Middle Last</p>				<p>4. DATE OF DEATH <u>APRIL 9</u> 19<u>66</u> Month Day Year</p>			
<p>5. SEX <u>F</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1-28-1872</u> 94 Yrs. Months Days</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.</u></p>	
<p>13. FATHER'S NAME <u>JOHN LOGSDON</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>LAURA COLE</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>		<p>17. INFORMANT <u>MRS. MAMIE FRB, WESTMINSTER</u> Address <u>RURAL MD.</u></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> DUE TO <u>General Cerebroarteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>July 5</u> 19<u>65</u>, to <u>Apr 9</u> 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>Apr 9</u> 19<u>66</u>, and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Julius Chapko</u></p>				<p>22b. DATE SIGNED <u>4/9/66</u></p>		<p>22c. PHYSICIAN'S NAME (Type) <u>Julius Chapko</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>23b. DATE THEREOF <u>4-11-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEM. UNIONTOWN, MD.</u></p>		<p>23d. LOCATION (City, town or county) (State)</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartzler & Sons</u></p>				<p>25a. REC'D BY REGISTRAR <u>APR 12 1966</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05102													
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>295 East Main St.</u>						d. STREET ADDRESS <u>295 East Main St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WILLIAM BROWN</u>						4. DATE OF DEATH Month Day Year <u>APRIL 18 1966</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>traffic engineer, rapid transit</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>George Richard Brown</u>						14. MOTHER'S MAIDEN NAME <u>Sophia Krick</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>193-20-1660</u>		17. INFORMANT <u>Mrs Florence F. Brown</u>			Address <u>same address</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5702</u> DUE TO (b) <u>mesenteric Thrombosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease Pulmonary emphysema</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May 26, 1963</u> , to <u>April 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1966</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>John S. Harshey</u>						22b. DATE SIGNED <u>4/18/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>						22d. ADDRESS <u>8 ANCHOR ST. WESTMINSTER, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster, Md.</u>			23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 22 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <div style="text-align: center;"> <div>1</div> <div>(M)</div> </div> <div>05103</div> </div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div style="text-align: right;"> <div>05102</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b 1 mo. 28 dys.						d. STREET ADDRESS 2916 Harford Road					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital											
3. NAME OF DECEASED (Type or print) First Thomas Middle Aloysius Last BROWN						4. DATE OF DEATH Month April Day 29 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-98		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (retired)				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Massachusetts			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Brown						14. MOTHER'S MAIDEN NAME Kitty Cant					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 012-05-0820		17. INFORMANT Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease + x x x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) PERIPHERAL ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
INTERVAL BETWEEN ONSET AND DEATH 1 YEAR YEARS											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 3-1-66 , 19____, to 4-29-66 , 19____, that (I) (we) last saw the deceased alive on 4/29 19 66 , and that death occurred at 11:50 AM , from the causes and on the date stated above.											
22a. SIGNATURE Samuel P. Wise, III						22b. DATE SIGNED 4-29-66					
22c. PHYSICIAN'S NAME (Type) Samuel P. Wise, III, M.D.						22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21781					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-2-66		23c. NAME OF CEMETERY OR CREMATORY Our Cathedral			23d. LOCATION (City, town or county) _____ (State) _____		
24. FUNERAL DIRECTOR Arthur A. Haight						25a. REC'D BY REGISTRAR Charles Judge					
25b. REGISTRAR'S SIGNATURE Charles Judge						DATE MAY 3 1966					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN ID Oy Om 13d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 21217 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City 21217 d. STREET ADDRESS Argyle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES Christopher CARTER First Middle Last						4. DATE OF DEATH 4 29 19 66 Month Day Year					
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-7-75		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) unknown Md.			12. CITIZEN OF WHAT COUNTRY? -- USA		
13. FATHER'S NAME unknown						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown --				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, Sykesville, Maryland Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. -- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --			
21. I certify that he (this hospital) attended the deceased from 4-16 , 19 66 to 4-29 , 19 66 , that he (we) last saw the deceased alive on 4/29 , 19 66 , and that death occurred at 12:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE SP Wise III						ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-29-66			
22c. PHYSICIAN'S NAME (Type) Sam P. Wise III						22d. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-4-66		23c. NAME OF CEMETERY OR CREMATORY Sharp Street.,		23d. LOCATION (City, town or county) (State) Sandy Spring, Md.			
24. FUNERAL DIRECTOR Robert L. Woodward						ADDRESS Robert L. Woodward		25a. REC'D BY REGISTRAR April 29-66		25b. REGISTRAR'S SIGNATURE Charles Judge	

MAY 3 1966



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05105

1. PLACE OF DEATH o COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 10 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u>		d. STREET ADDRESS <u>Route 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>A.</u> Last <u>Conaway</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1886</u>
9. AGE (In years last birthday) yrs <u>80</u>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Pickett</u>		14. MOTHER'S MAIDEN NAME <u>Eliza J. Penn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Arthur R. Conaway</u>		Address <u>Same As Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, Hemiplegia</u> <u>321X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertension, Arteriosclerosis, generalized;</u> DUE TO (c) <u>Coronary thrombosis, Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1965</u> <u>through</u> <u>4.13.66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 65</u> to <u>4.13.66</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>66</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. <u>Sykesville, Maryland</u> <u>April 14, 1966</u> PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church of God Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		24. REC'D BY REGISTRAR <u>APR 18 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MAY 1966
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND05106
05105
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster, Md.		c. LENGTH OF STAY IN 1b 1 1/2 Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Meadow View Nursing Home Westminster, Md. R. D. 1		d. STREET ADDRESS Westminster, Md. R. D. 2	
3. NAME OF DECEASED (Type or print) First Garfield Middle David Last Crowl		4. DATE OF DEATH Month April Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1880
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Crowl		14. MOTHER'S MAIDEN NAME Julia Bankert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-4517A	
17. INFORMANT Bethel M. Smith		Address 400 Baltimore St. Hanover, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema 32771 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 years OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility		INTERVAL BETWEEN ONSET AND DEATH 20 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 1965 to April 27, 1966 , that (I) (we) last saw the deceased alive on April 26, 1966 , and that death occurred at 555 AM , from the causes and on the date stated above.			
22a. SIGNATURE L. L. Potter M.D.		22b. DATE SIGNED April 27, 1966	
22c. PHYSICIAN'S NAME (Type) L. L. POTTER M.D.		22d. ADDRESS LITTLESTOWN, PA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/66	
23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co., Md.	
24. FUNERAL DIRECTOR Richard A. Little, Littlestown, PA.		25a. REC'D BY REGISTRAR APR 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film 3375 4/21/66 mn

05107

CERTIFICATE OF DEATH

05106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN b. 3 yrs. 7 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21205		d. STREET ADDRESS 3203 McElderry Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle John Last DIEGELMAN		4. DATE OF DEATH Month April Day 8 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-1894
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Mins 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Diegelman		14. MOTHER'S MAIDEN NAME Christine Offenstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 215-09 4293	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEPTICEMIA FROM INFECTED DECUBITUS ULCER			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9-62 , 19 62 , to 4-8 , 19 66 , that (I) (we) last saw the deceased alive on 4-8 19 66 , and that death occurred at 7^{PM} M, from causes and on the date stated above.			
22a. SIGNATURE Robert N. Deeb, M.D.		22b. DATE SIGNED 4-8-66	
22c. PHYSICIAN'S NAME (Type) Robert N. Deeb, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/66	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Hoffman Funeral Home Bldg. & Bldg.		25. REGD. BY REGISTRAR APR 13 1966	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05108 CERTIFICATE OF DEATH 05107									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 23 yrs. 8 mos. 2 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JOSEPH Middle (NMN) Last DUNN					4. DATE OF DEATH Month April Day 14 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-1886		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher C. Dunn					14. MOTHER'S MAIDEN NAME Amelia Eser				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records, Springfield State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with alcohol intoxication, with psychotic reaction.									INTERVAL BETWEEN ONSET AND DEATH months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-12-42 , 19 19 , to 4-14-66 , 19 19 , that (I) (we) last saw the deceased alive on 4-14-66 , 19 19 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Antonius Glahn, M.D.					22b. DATE SIGNED 4-14-66		22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		
22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784									
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/16/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202					25a. REC'D BY REGISTRAR APR 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G376 4/26/66 mh

CERTIFICATE OF DEATH

05109

05108

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 1 mo. 2 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No fixed address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle (NMN) Last ETON		4. DATE OF DEATH Month April Day 9 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1899 9. AGE (In years last birthday) yrs 66 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Massachusetts 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1917-1919		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records, Springfield State Hospital Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH no.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-7-66 , 19 66 , to 4-9 , 19 66 that (I) (we) last saw the deceased alive on 4-9 , 19 66 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert M. Deeb		22b. DATE SIGNED 4-9-66	
22c. PHYSICIAN'S NAME (Type) Robert M. Deeb, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF April 12, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery, Baltimore Md.	23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.
24. FUNERAL DIRECTOR Frank H. Stenel, Sykesville 8, Md.		25a. REC'D BY REGISTRAR DATE APR 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

05110

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05109

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>43 JOHN STREET</u>				d. STREET ADDRESS <u>43 JOHN STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROY CHARLES GAMBER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 15 1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 19 1893</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>QUARTER MASTER - K.E.W. ADMINISTRATIVE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>RUBIN G. GAMBER</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. HARRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>213-05-1514 A</u>			
17. INFORMANT <u>WIFE MRS ROY C. GAMBER</u>				Address <u>43 JOHN ST. WESTMINSTER, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>44 yrs Congestive heart failure, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiovascular atherosclerosis</u> DUE TO (c) <u>Renal nephrosclerosis & systemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from <u>2</u> , 19 <u>66</u> , to <u>4</u> , 19 <u>66</u> , that I (we) last saw the deceased alive on <u>4/14</u> , 19 <u>66</u> , and that death occurred at <u>5:15</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William R. O'Rourke</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM R. O'ROURKE</u>				22d. ADDRESS <u>150 W. MAIN ST. WESTMINSTER, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ARCADIA MD</u>	
24. FUNERAL DIRECTOR <u>James G. Saffell Jr.</u>				ADDRESS <u>WESTMINSTER, MD</u>		25a. REC'D BY REGISTRAR <u>APR 18 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05111

CERTIFICATE OF DEATH

05110

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 6yrs. 6mos. 12dys.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 5905 Kavon Avenue	
3. NAME OF DECEASED (Type or print) AUGUSTA		First (NMN)		Last GOLDERMAN	
4. DATE OF DEATH APRIL 14		Month 14		Day 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-1-1874		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Unk.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Lenhart		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease + 200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10-2-59 , 19 to 4-14-66 , 19, that (I) (we) last saw the deceased alive on 4-14-66 , 19, and that death occurred at 11:50 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-14-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/1966		23c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Wm. F. Fickman & Son			
25a. REC'D BY REGISTRAR APR 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05112											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3 Weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pollen Nursing Home</u>						d. STREET ADDRESS <u>Gaither Manor Apt's.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT N. HAMMOND</u>						4. DATE OF DEATH <u>APRIL 18</u> 19 <u>66</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-1909</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Wm Lee Hammond</u>						14. MOTHER'S MAIDEN NAME <u>Josephine Forsythe</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Mr. Arthur Hammond - Ellicott City, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> DUE TO (b) <u>Intra-aqueal hemorrhage</u> DUE TO (c) <u>Terminal C of Larynx</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 minute</u> <u>20 minute</u> <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3.24, 1966</u> to <u>4.18, 1966</u> , that (I) (we) last saw the deceased alive on <u>4.18, 1966</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Sani Okutman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4.19.66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>						22d. ADDRESS <u>Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK Grove Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles J...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05113					05112					
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>			c. LENGTH OF STAY IN 1b <i>41 yrs.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <i>14 New Street</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Grace Rebecca Houston</i>			4. DATE OF DEATH Month Day Year <i>April 3 1966</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/15/1886</i>		9. AGE (in years last birthday) <i>80 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Columbus Nicholas Hershey</i>					14. MOTHER'S MAIDEN NAME <i>Columbia Francis</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>215-074633</i>		17. INFORMANT Name Address <i>Christine Gough, Manchester, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>8 yrs</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arteriosclerosis</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <i>Nov</i> , 1947, to <i>4/3</i> , 1966, that (1) (we) last saw the deceased alive on <i>4/1</i> , 1966, and that death occurred at <i>8:30 P.</i> from the causes and on the date stated above.										
22a. SIGNATURE <i>W. H. Foard</i>			22b. DATE SIGNED <i>4/4/66</i>			22c. PHYSICIAN'S NAME (Type) <i>W. H. Foard M.D.</i>			22d. ADDRESS <i>Manchester, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4/6/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Immanuel Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Manchester Md.</i>			
24. FUNERAL DIRECTOR <i>Tipton-Eline Fun. Home, Hampstead, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>APR 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

05114

CERTIFICATE OF DEATH

Reg. Dist. No. 05113

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Route # 1M</u>				d. STREET ADDRESS <u>P.O. Route # 1M</u>			
3. NAME OF DECEASED (Type or print) First <u>Birdie</u> Middle <u>Belle</u> Last <u>Hess</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1890</u>	9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hess</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mrs. Ralph Shipley R#1M Taneytown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>4/5/66</u> 19 to <u>4/6/66</u> 19, that I last saw the deceased alive on <u>4/5/66</u> 19, and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.E. Robertson</u>		M.D. <u>New Windsor, Md.</u>		DATE SIGNED <u>4/6/66</u>			
PHYSICIAN'S NAME (Type) <u>M.E. Robertson</u>		<u>New Windsor, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/8/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.O. Fuss & Son</u>				24a. REC'D BY REGISTRAR <u>APR 7 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

05115

05114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21</u>			
c. LENGTH OF STAY IN 15 <u>2 years</u>				d. STREET ADDRESS <u>1724 Glen Curtis Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>E.</u> Last <u>Holt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1892</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitation Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Holt</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Stottlenmyer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW 1</u>	
16. SOCIAL SECURITY NO. <u>213-18-0658</u>		17. INFORMANT <u>Markel E. Holt</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes, severe; Caronary thrombosis;</u> (b) <u>Cardiac failure; Pneumonia;</u> (c) <u>Cerebral vascular accident.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Address Balto. 21, Md. 23 Ridgemoor Rd.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1965</u> through <u>April 17, 1966</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>April 17</u> , 1966, that (I) (we) last saw the deceased alive on <u>April 17</u> , 1966, and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above	
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>April 18, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		24b. ADDRESS <u>P.O. Box 241 Sykesville, Md.</u>		25a. DATE <u>APR 20 1966</u>		25b. SIGNATURE <u>James Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05116

CERTIFICATE OF DEATH

05115

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		d. STREET ADDRESS <u>161 W. Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER FRANKLIN HUTCHINS</u>		4. DATE OF DEATH <u>APRIL 9 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1885</u>
9. AGE (In years lost birthday) <u>81</u> yrs		10. F UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Retail</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hutchins</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Webb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOC. A. SECURITY NO. <u>216-05-8819</u>	
17. INFORMANT <u>2 Mrs Walter F. Hutchins</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1966</u> , to <u>April 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1966</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>4/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Md.</u>
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

2021 Film G375 471785
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6 yrs./25 das d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS Norwood Road, Rt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Geraldine Middle Marie Last JONES		4. DATE OF DEATH Month April Day 2, Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1937
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert F. Jones		14. MOTHER'S MAIDEN NAME Ida Marie Spreen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) None	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of larynx by piece of frankfurter. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7217 DUE TO (b) Pulmonary edema. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CBS assoc. with other intracranial infection other than Syphilis without qualifying phrase. Encephalitis in childhood.		INTERVAL BETWEEN ONSET AND DEATH mins. mins.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While receiving noon meal, piece of frankfurter became lodged in trachea.	
20c. TIME OF INJURY Month, Day, Year 12:45 Hour 4/2 p.m. 19 66		20d. INJURY OCCURRED While at work Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		22. DATE SIGNED 4-2-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-5-66	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town or county) (State) Lima, Ohio	
24. FUNERAL DIRECTOR Harry Wm Haight ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR APR 6 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

05117

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alverta May Keller		4. DATE OF DEATH Month Day Year 4 12 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1883
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Steven G. Lloyd		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gilbert Keller, Upperco, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR INSUFFICIENCY DUE TO (b) CEREBRAL ARTERIO-SCLEROSIS DUE TO (c) YEARS		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① ARTERIO-SCLEROTIC HEART DISEASE-DECOMPENSATED ② BRONCHO-PNEUMONIA		19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/2, 1966 to 4/12, 1966 , that (I) (we) last saw the deceased alive on 4/12, 1966 , and that death occurred at 6:35 M. from causes and on the date stated above.			
22a. SIGNATURE Vincent J. Kowalski		22b. DATE SIGNED 4/12/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/66	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Finkeburg, Md.	
24. FUNERAL DIRECTOR Tipton-Eline Funeral Home, Hampstead Md.		25a. REC'D BY REGISTRAR APR 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>1</div> <div>M</div> </div> <div> <div>05118</div> <div>05118</div> </div>										
1. PLACE OF DEATH a. COUNTY <u>Carrall</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> c. LENGTH OF STAY IN b. <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs Md</u> d. STREET ADDRESS <u>10507 Lester Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Miles</u> First <u>(N.M.N)</u> Middle <u>Keller</u> Last					4. DATE OF DEATH <u>4</u> Month <u>9</u> Day <u>1966</u> Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/1/86</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Jacob Keller</u>					14. MOTHER'S MAIDEN NAME <u>Nettie Hertsgo</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u>					16. SOCIAL SECURITY NO. <u>205-30-2532</u>		17. INFORMANT <u>Springfield Hospital</u> Address <u>Records Sykesville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS senile brain disease with psychotic reaction</u>										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)			20h. (City or town) (County) (State)			20i. (City or town) (County) (State)	
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>3-18-</u> 19 <u>66</u> to <u>4-9-</u> 19 <u>66</u> , that <u>he</u> (we) last saw the deceased alive on <u>4-9</u> 19 <u>66</u> , and that death occurred at <u>7:50</u> PM, from the causes and on the date stated above.										
22a. SIGNATURE <u>Suha Oggun</u>					22b. DATE SIGNED <u>4-10-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u>					22d. ADDRESS <u>Springfield State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>13 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Airy Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Lancaster Co., Penna.</u>		
24. FUNERAL DIRECTOR <u>Thomas E. Humphrey</u> ADDRESS <u>8434 Germantown Ave. Phila. Pa. 2074</u>					25a. REC'D BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



05120

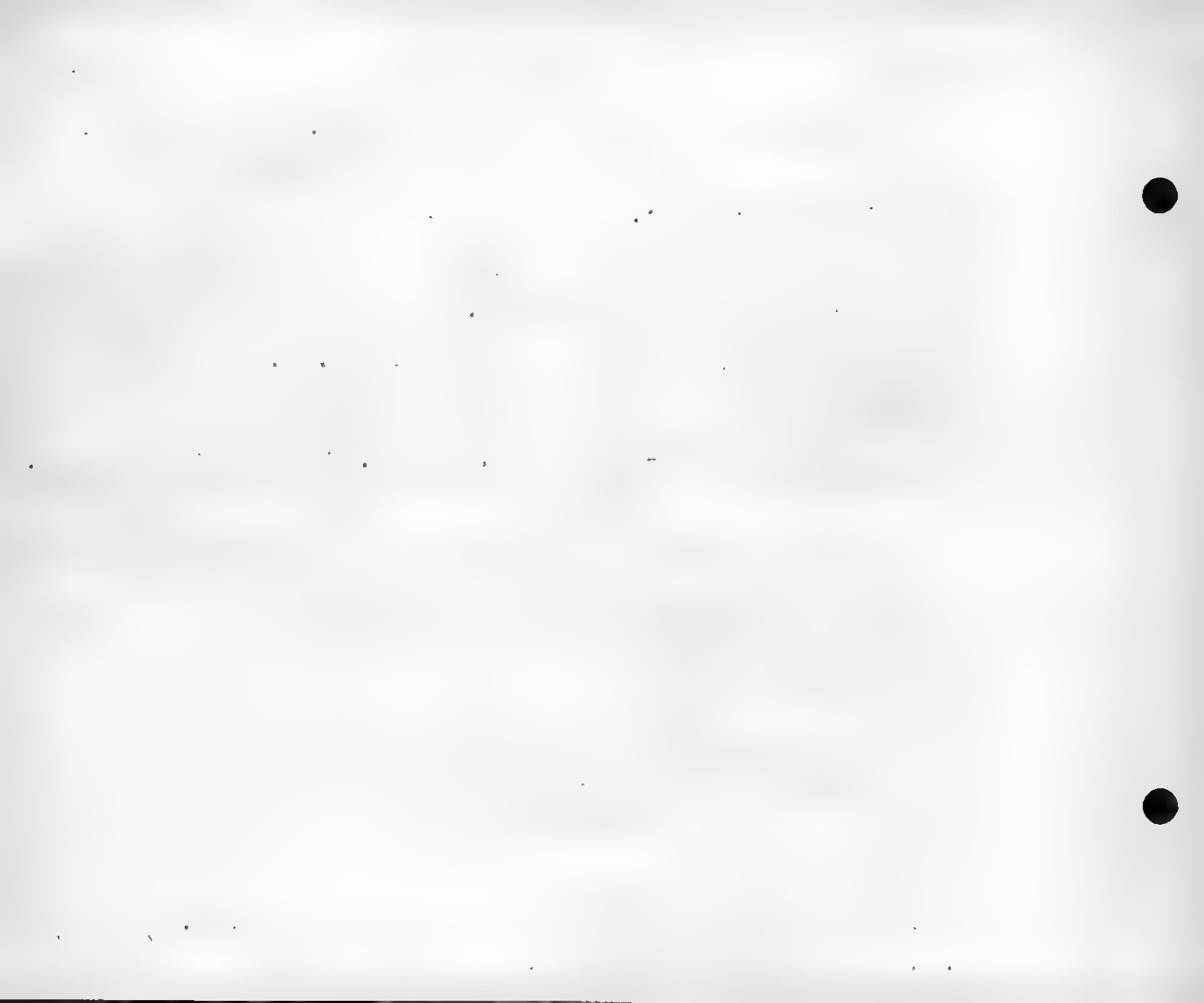
CERTIFICATE OF DEATH

05119

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Westminster		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
3 NAME OF DECEASED (Type or print) Daniel Park Kieffer		4. DATE OF DEATH Month 4 Day 17 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 3, 1886
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Election Board of Baltimore County		10b KIND OF BUSINESS OR INDUSTRY Baltimore Co. Md.	11 BIRTHPLACE (County & State, or foreign country) Baltimore Co. Md.
13. FATHER'S NAME Stephen Kieffer		14. MOTHER'S MAIDEN NAME Ruth Loflin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-6502	
17 INFORMANT Mrs. Rabeth S. Kieffer		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA - RUL + RLL DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/13, 1966 to 4/17, 1966 , that (I) (we) last saw the deceased alive on 4/17, 1966 , and that death occurred at 8:38 M, from causes and on the date stated above			
22a. SIGNATURE Vincent J. Frosin		22b. DATE SIGNED 4/17/66	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/20/66	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Boring, Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons		25d. RECEIVED BY REGISTRAR APR 19 1966	
ADDRESS Reisterstown, Md.		25b. DECEASED'S SIGNATURE J. F. Eline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE HEALTH DEPT. M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05120

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte. 1

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
d. STREET ADDRESS Rte. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) Homer A. Leinart
First Middle Last
4. DATE OF DEATH 4 11 19 66 Month Day Year
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 11/17/1911 9. AGE (In years last birthday) 54 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Farmer School Bus Driver 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Adams Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.G.
13. FATHER'S NAME John C. Leinart 14. MOTHER'S MAIDEN NAME Anna Homer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. 16. SOCIAL SECURITY NO. 165-10-7239 17. INFORMANT Wagie Buckel Kunkel, Manchester Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poisoning
9731 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. inhalation of auto exhaust fumes
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 4 11 19 66 Hour a.m. ? p.m. ? 20d. INJURY OCCURRED While ☐ at work Not While ☒ at work home 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) Manchester (County) Carroll (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 4/12/66
NAME (Type) Werner U. Spitz, M.D. Address (Street, city, town, or county) Hammer Pa. P. O. York Pa.
22a. BURIAL, CREMATION, or REMOVAL (Specify) Buried 22b. DATE THEREOF 4/14/66 22c. NAME OF CEMETERY OR CREMATORY St. Bartholomew's 22d. LOCATION (City, town, or county) Hammer Pa. P. O. York Pa.
23. FUNERAL DIRECTOR Wayne V. Kenworthy 24. REC'D BY REGISTRAR Charles Judge DATE APR 14 1966 24b. REGISTRAR'S SIGNATURE Charles Judge



CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg
c. LENGTH OF STAY IN 1b 1 year
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New Windsor
d. STREET ADDRESS Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Florence H. Lindsay
First Middle Last
4. DATE OF DEATH April 8 1966 Month Day Year
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH July 9, 1873 9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Theodore Harman 14. MOTHER'S MAIDEN NAME Martha Repp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT RFD 5 Westminster, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) arteriosclerotic CVD
4/11/66 DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that (I) (this hospital) attended the deceased from 8/1/56 19..... to 4/8/66 19....., that (I) (we) last saw the deceased alive on 4/8/66 19....., and that death occurred at 10:45 PM from the causes and on the date stated above.

22a. SIGNATURE M. E. Robertson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED _____
22c. PHYSICIAN'S NAME (Type) M. E. Robertson 22d. ADDRESS New Windsor, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/11/66 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery 23d. LOCATION (City, town or county) New Windsor Rural (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ed Hertzler & Sons New Windsor, Md 25a. REC'D BY REGISTRAR APR 12 1966 25b. REGISTRAR'S SIGNATURE J Charles Judge

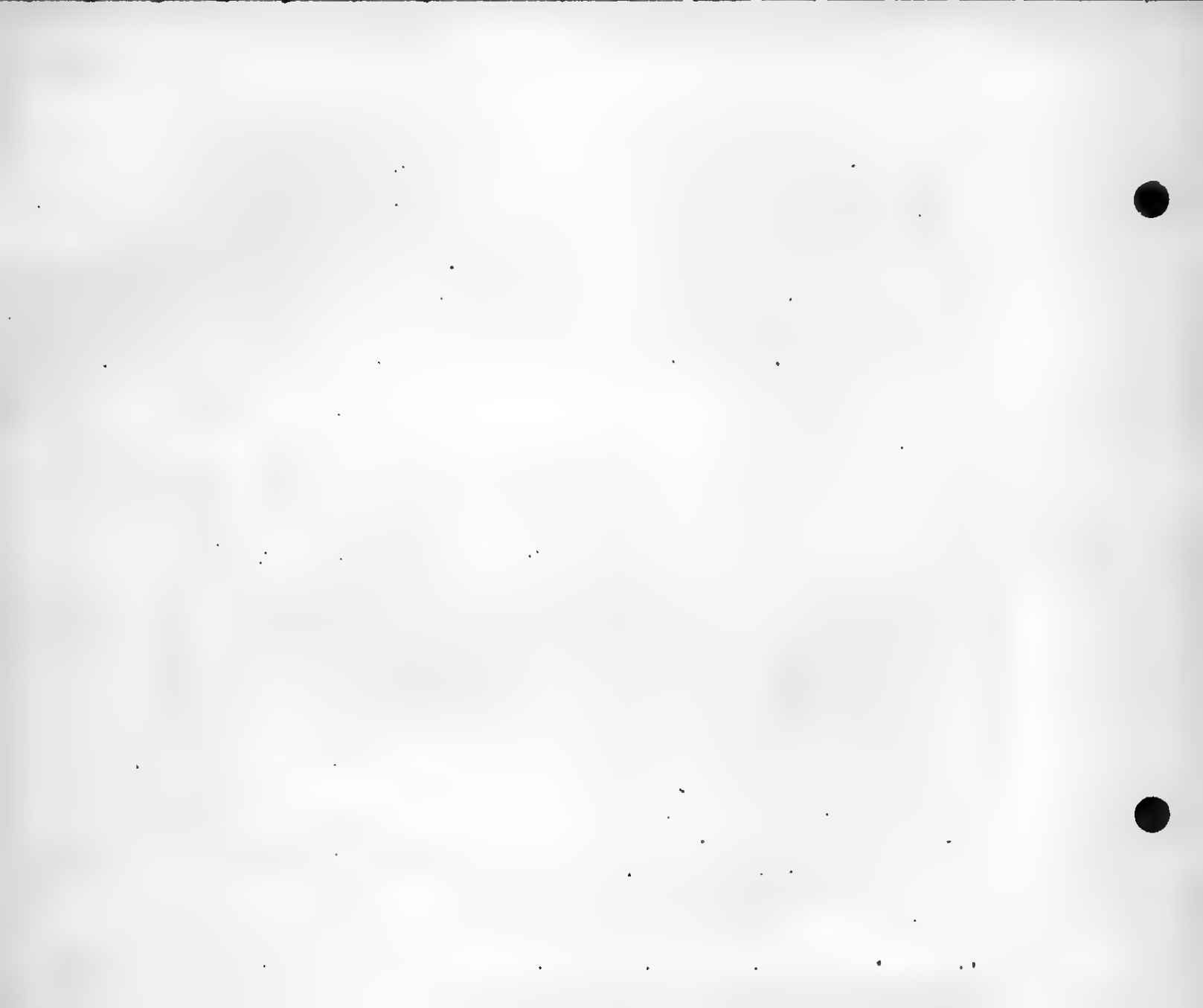
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05122									
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - SYKESVILLE c. LENGTH OF STAY IN MD. 9 YR. 1 MO. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRINGFIELD STATE Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 5428 SEFTON AVE. BALTIMORE - 14 - MD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE BENJAMIN LUTZ					4. DATE OF DEATH Month Day Year APRIL 16 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-93		9. AGE (in years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George LUTZ					14. MOTHER'S MAIDEN NAME Rebecca JOHNSON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 220-18-2623		17. INFORMANT HOSPITAL RECORD -		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Intermittent Coronary Artery Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 4 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-15, 1957 to 4-16, 1966, that (I) (we) last saw the deceased alive on 4-16, 1966, and that death occurred at 4 PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert M. Deeb</u> 22c. PHYSICIAN'S NAME (Type) ROBERT M. DEEB						22b. DATE SIGNED 4-16-66 22d. ADDRESS S.S. Hospital - Sykesville, MD.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St.						25a. REC'D BY REGISTRAR APR 19 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05124

CERTIFICATE OF DEATH

05123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 42yrs.5mos.25dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS (unknown) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) LENA (MADELINE) First (none) Middle MANNING Last 4 DATE OF DEATH Month APRIL Day 6 Year 19 66		5 SEX Female 6 CO. OR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH 11-11-92 9. AGE (In years last birthday) yrs 73 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11 BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME (Unknown) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. None 17 INFORMANT Records, Springfield State Hospital		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (it) (this hospital) attended the deceased from 10-11 , 19 66 , to 4-6 , 1966, that (it) (we) last saw the deceased alive on 4-6 , 19 66 , and that death occurred at 12:30 P.M. from causes and on the date stated above. 22a. SIGNATURE Ilse Kamm M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D. 22d. ADDRESS Sykesville, Maryland 22b. DATE SIGNED 4-6-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-11-1966 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24 FUNERAL DIRECTOR Lilly & Zeiler Inc.. 190107 Eastern Ave. 25a. REC'D BY REGISTRAR DATE APR 11 1966 25b. REGISTRAR'S SIGNATURE Charles J. Jago	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN ID <u>3yrs.7mos.17dys.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> d. STREET ADDRESS <u>202 Homewood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>CLARICE</u> Last <u>MASSEY</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-02</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress/housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roland Kelly</u>					14. MOTHER'S MAIDEN NAME <u>Adeline Shea</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>(none)</u>		17. INFORMANT <u>Records, Springfield State Hospital</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO <u>Arteriosclerotic coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome associated with presenile brain disease, without qualifying phrase</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (it) (this hospital) attended the deceased from <u>8-27</u> , <u>1962</u> , to <u>4-14</u> , <u>1966</u> , that (it) (we) last saw the deceased alive on <u>4-14</u> , <u>1966</u> , and that death occurred at <u>9:50A</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22b. DATE SIGNED <u>April 14, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M.D.</u>					22d. ADDRESS <u>Sykesville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Stephens</u>		23d. LOCATION (City, town or county) (State) <u>Delmar, Del.</u>		
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Charles W. Hyman - Delmar, Del.</u>						25a. REC'D BY REGISTRAR <u>APR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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VR A15 (4)
20 M 1/66

05126

CERTIFICATE OF DEATH

05125

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timberburg R.D. #1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>				d. STREET ADDRESS <u>Sullivan Trade Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD WESLEY McELWAIN, SR.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10, 1923</u>	
9. AGE (In years last birthday) <u>42</u> yrs		10. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sewage work WMC village</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kittanning Pa. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hasting McElwain</u>				14. MOTHER'S MAIDEN NAME <u>Steele Harter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>205-12-4228</u>		17. INFORMANT Name <u>Mrs. Shelma S. McElwain</u> Address <u>Timberburg Rd. R.D. #1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of the lung</u> (c) <u>Carcinoma of the lung</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 30</u> , 19 <u>66</u> , to <u>April 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>66</u> , and that death occurred at <u>11:35</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>Garcho St. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lane Haven Burial</u>		23d. LOCATION (City or Town) (County) (State) <u>Kittanning Pa.</u>	
24. FUNERAL DIRECTOR <u>J. S. Imperio, Jr. Westminster Md.</u>				25a. REC'D BY REGISTRAR <u>APR 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05127

CERTIFICATE OF DEATH

05126

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN IS 6mo. 11days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2806 Roselawn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Laura Middle Virginia Last Mettee		4 DATE OF DEATH Month 4 Day 12 Year 19 66	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 03/12/80
9 AGE (In years) 86 yrs		10 IF UNDER 1 YEAR Months 12 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Tydings		14. MOTHER'S MAIDEN NAME Mary Elizabeth Main	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO 218-46-2460	
17. INFORMANT Springfield Hospital records-Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Uremia DUE TO (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH days days years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with senile brain disease without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 10/1/65 , to 4/12/66 , saw the deceased alive on 4/12/66 , and that death occurred at 8:30 P.M. from causes and on the date stated above.		22a. SIGNATURE Edmee J. Reeves, M. D. 22c. PHYSICIAN'S NAME (Type)	
22b. DATE SIGNED 4/13/66		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF April 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. REG. BY REGISTRAR APR 18 1966		25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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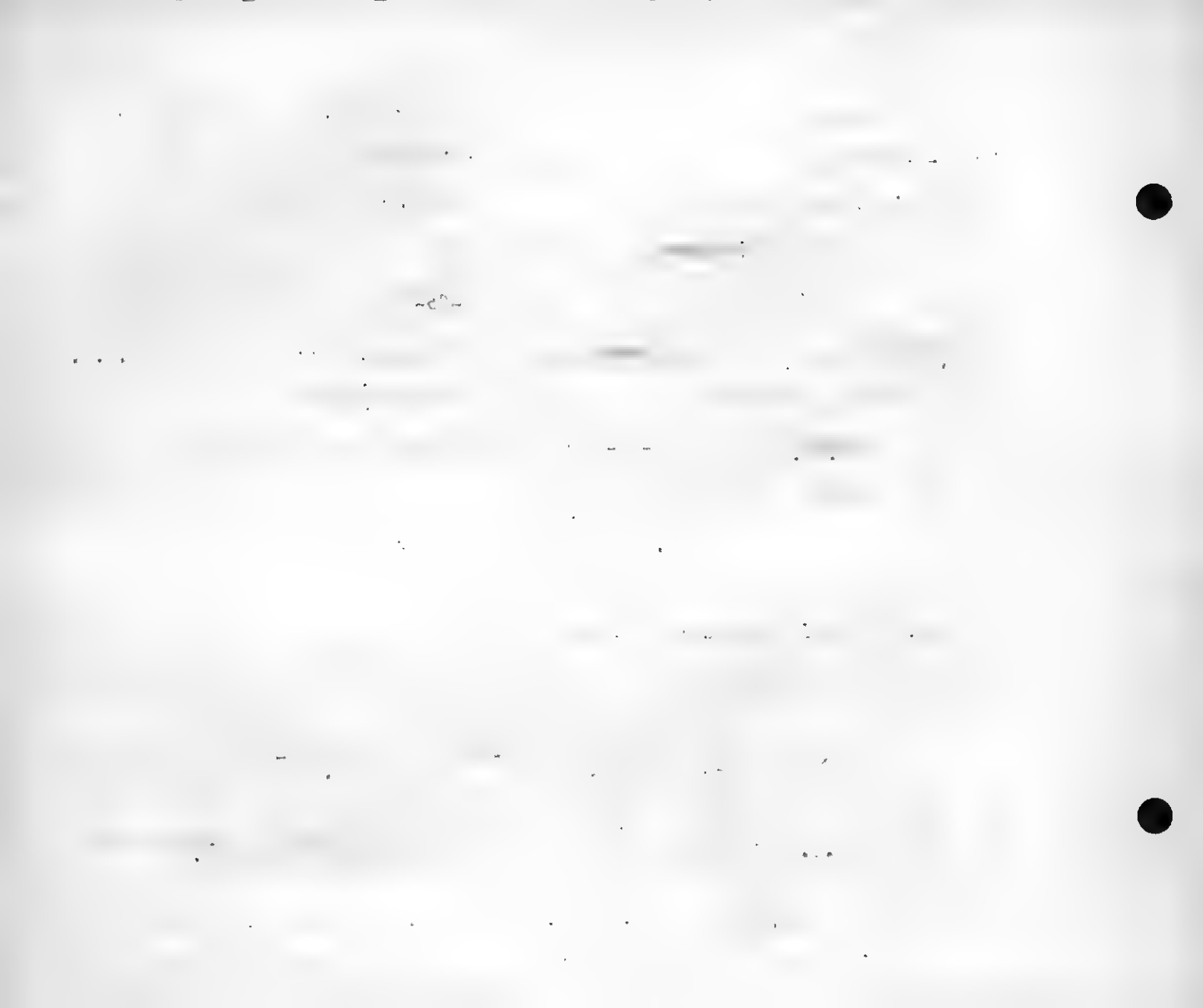
VR A15 (4)
20M 1/65

05128

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05127

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Sykesville c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allego c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 12 Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Nicholas Morrissey	4. DATE OF DEATH 4 30 19 66	5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-25-94 9. AGE (In years, birthdate) 71 yrs. 10. FUNDER 1 YEAR <input type="checkbox"/> 11. FUNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Owner & Prop.		10b. KIND OF BUSINESS OR INDUSTRY Antique business	
11. BIRTHPLACE (County & State, or foreign country) Maryland Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Morrissey		14. MOTHER'S MAIDEN NAME Annie Farlong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, Yes (unknown) (If so, name war or dates of service) W. W. # 1)		16. SOCIAL SECURITY NO. 220-10-7120	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-21-66 Branchopneumonia DUE TO (b) Arterio-sclerotic cardiovascular disease DUE TO (c) Generalized arterio-sclerosis.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome of Unknown Cause			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 4-30 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4-21-66 (this hospital) attended the deceased from 4-21 , 19 66 , to 4-30 , 19 66 , that 1 (we) last saw the deceased alive on 4-30 , 19 66 , and that death occurred at 1 A. m., from the causes and on the date stated above.			
22a. SIGNATURE R.G. Lajonchere MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R.G. Lajonchere		22d. ADDRESS Springfield State Hospital Sykesville Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/66	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR MAY 3 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

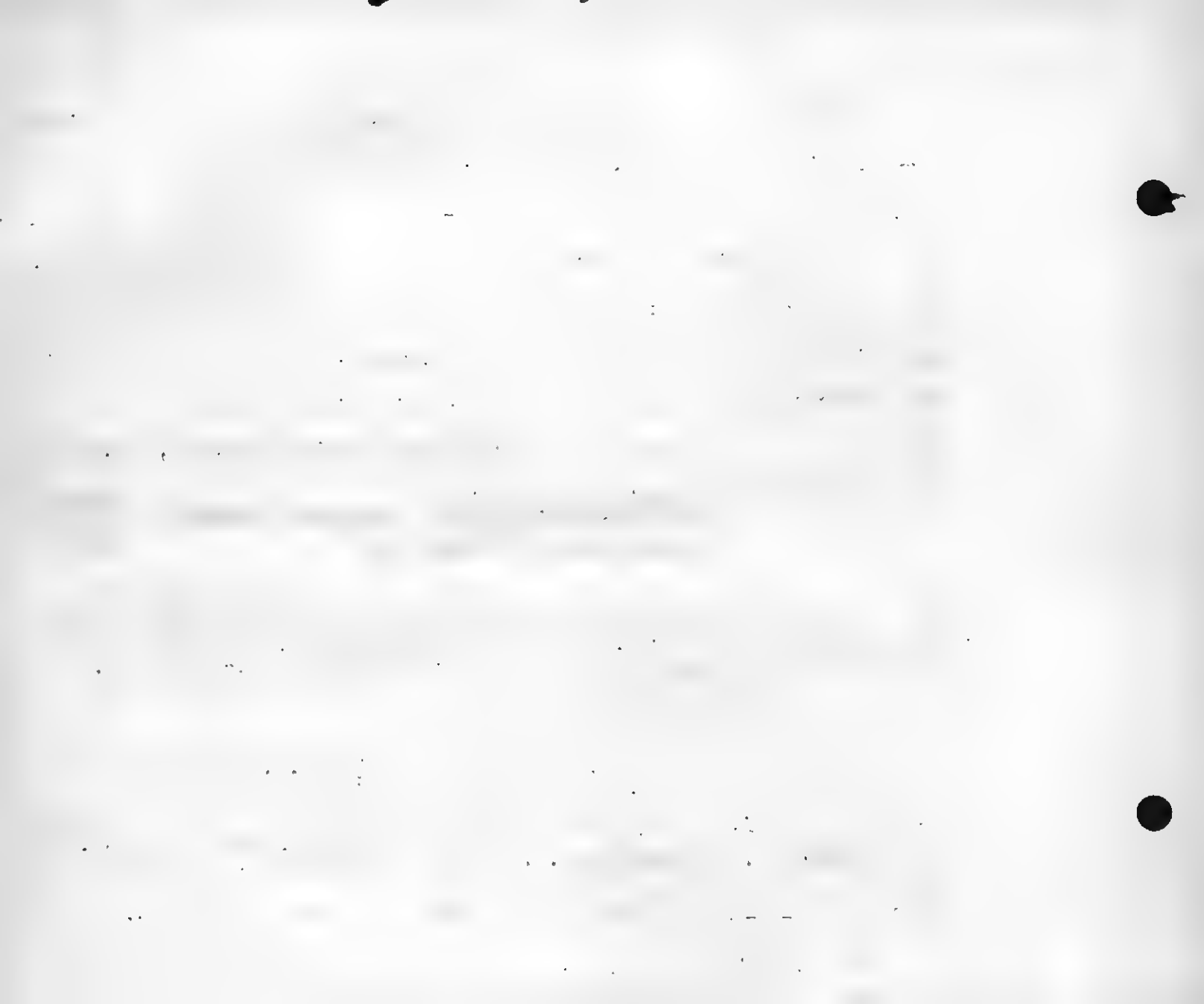


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05129 CERTIFICATE OF DEATH 05128									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 1yr. 9days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gapland d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Beulah		First Virginia		Middle Moss		Last Moss		4. DATE OF DEATH Month 4 Day 5 Year 1966	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/21/92		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Cochran					14. MOTHER'S MAIDEN NAME Ida Reeder				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records, Sykesville			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic Heart Disease (b) Branchopneumonia DUE TO Chronic brain syndrome with circulatory disturbance other than cerebral arteriosclerosis (arteriosclerosis & hypertensive cardiovascular disease) with psychotic reaction. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with circulatory disturbance other than cerebral arteriosclerosis (arteriosclerosis & hypertensive cardiovascular disease) with psychotic reaction.									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that (this hospital) attended the deceased from 3/26/1965 to 4/5/1966 , that (we) last saw the deceased alive on 4/5/1966 , and that death occurred at 2:00 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal		22b. DATE SIGNED 4/5/66		22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-7-66		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery		23d. LOCATION (City, town or county) (State) Locust Grove, Md.			
24. FUNERAL DIRECTOR Wm. F. Balt...		24a. REC'D BY REGISTRAR APR 11 1966		24b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05130

05129

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middleburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brookfield Manor Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Motter</u> Last <u>Motter</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1882</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Baker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shriner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Clarence J. Motter, Taneytown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Cerebral atherosclerosis and thrombosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/8/66</u> , 19... to <u>4/2/66</u> , 19... that (I) (we) last saw the deceased alive on <u>4/2/66</u> , 19... and that death occurred at <u>11:30</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>J.H. Caricofe</u>		22b. DATE SIGNED <u>4/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.H. Caricofe</u>		22d. ADDRESS <u>Union Bridge, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 5, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Emmitsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins</u>		25a. REC'D BY REGISTRAR <u>C.O. Fuss & Son, Taneytown, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 5 1966</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05131

05130

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		2. USUAL RESIDENCE (Where deceased lived, if institut on-- Residence before admission) a. STATE Maryland c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 311 Cathedral Street	
3. NAME OF DECEASED (Type or print) First Margaret Middle Dolores Last Murray		4. DATE OF DEATH Month 4 Day 24 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/82
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 4 Days 24	IF UNDER 24 HRS. Hours 19 Min 66
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Registered nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel A. L. Murray	
14. MOTHER'S MAIDEN NAME Anna Cecilia Ward		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Springfield Hospital records--Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Carcinoma breast metastasis DUE TO (b) years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from 5/18/ , 19 55 , to 4/24/ , 19 66 that (X) (we) last saw the deceased alive on 4/24/ , 19 66 , and that death occurred at 1:45 M, from causes and on the date stated above.	
22a. SIGNATURE Naci N. Buyukunsal, M. D.		22b. DATE SIGNED 4/24/66	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-27-66	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Harry Haight Sykesville, Md.		25a. REC'D BY REGISTRAR APR 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05152

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05151

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 0y 11m 8d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown 21740 d. STREET ADDRESS 197 W. Wilson Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Preston ELMIRE MYERS First Preston Middle ELMIRE Last MYERS				4. DATE OF DEATH April 28 1966 Month April Day 28 Year 1966			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-1881	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) Cearioss Wash Co Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Myers				14. MOTHER'S MAIDEN NAME Mary A. Sprinkle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 217-12-1840		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction						INTERVAL BETWEEN ONSET AND DEATH 8 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) --				20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19			
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --			
20f. (City or town) -- (County) -- (State) --				21. I certify that we (this hospital) attended the deceased from 5-20- , 1965 , to 4-28 , 1966 , that we (we) last saw the deceased alive on 4/28 , 1966 , and that death occurred at 2:45 PM, from the causes and on the date stated above.			
22a. SIGNATURE SP Wise III				22b. DATE SIGNED 4/28/66			
22c. PHYSICIAN'S NAME (Type) Sam P. Wise III				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/66		23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		23d. LOCATION (City, town or county) (State) Broadfording Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown ADDRESS Hagerstown Md.				25. REC'D BY REGISTRAR MAY 2 1966 DATE Charles Judge			



05133

CERTIFICATE OF DEATH

05132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If acts de corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b) <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>				d. STREET ADDRESS <u>Mineral Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK NICKOLES</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. CO. OR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 2, 1883</u>	
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u>		11. IF UNDER 24 HRS Hours <u>19</u> Min. <u>66</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Nickoles</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rauterback</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Michael Nickoles</u> Address <u>Sykesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PERIPHERAL MYOCARDIAL INFARCT</u> 4 <u>1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>66</u> to <u>4/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Vincent J. Ficocci</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FICOCCHI</u>				22d. ADDRESS <u>Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park View Memorial</u>		23d. LOCATION (City or town) (County) (State) <u>Sykesville (Carroll, Md.)</u>	
24. FUNERAL DIRECTOR <u>Arthur A. Haight</u>		ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05133

CERTIFICATE OF DEATH

05133

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 weeks</u>				d. STREET ADDRESS <u>2109 Harover Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woodbine' N. H. Miller's Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Brewster</u> Last <u>Pericks</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1885</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Asst. Station Master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Terminal Co.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thomas B. Pericks</u>				14. MOTHER'S MAIDEN NAME <u>Jacet Laurie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>David C. Pericks</u>				Address <u>539 Gladstone Blvd. Kansas City, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive coronary thrombosis</u> <u>4/20/1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized.</u> (c), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1966</u> , to <u>April 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1966</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				22b. DATE <u>April 18, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>	
22d. ADDRESS <u>Sykesville, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>19 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>APR 21 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05135

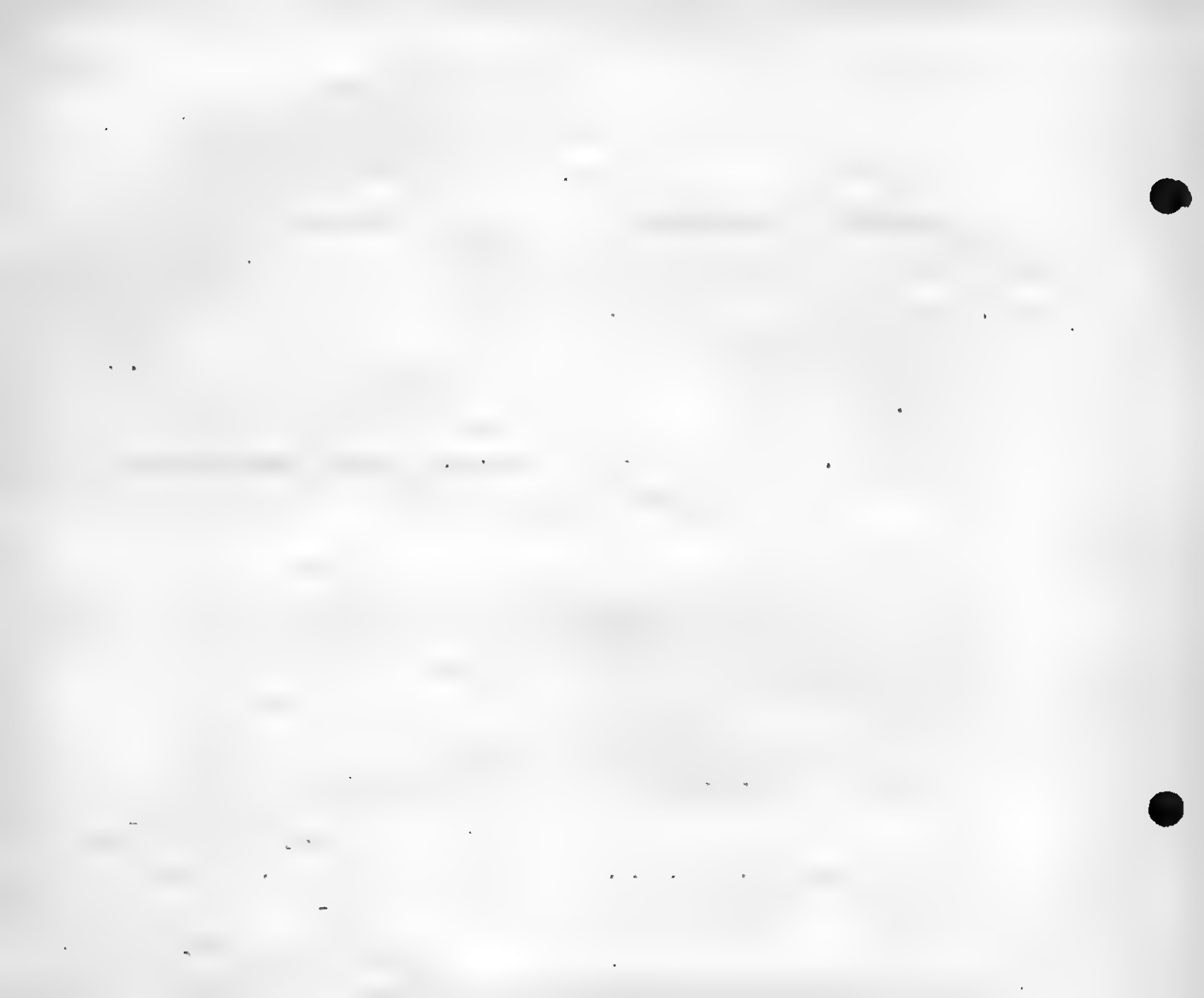
CERTIFICATE OF DEATH

05134

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN IL 25 dys.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS No fixed address	
3. NAME OF DECEASED (Type or print) First SHERMAN Middle HENRY Last PHEPPER		4. DATE OF DEATH Month APRIL Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-11
9. AGE (In years post birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours M.n 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Anne Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes (Unk.)		16. SOCIAL SECURITY NO. 218-05-5888	
17. INFORMANT Records, Springfield State Hospital		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 			INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-21-66 , 19 to 4-16-66 , 19 , that (I) (we) last saw the deceased alive on 4-16-66 , 19 , and that death occurred at 9:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 4-19-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL-CREATION, REMEM (Specify)	23b. DATE THEREOF 4-22-66	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE U. of Md.	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.
24. FUNERAL DIRECTOR Howell Funeral Home		25a. REC'D BY REGISTRAR APR 25 1966	
ADDRESS Baltimore		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



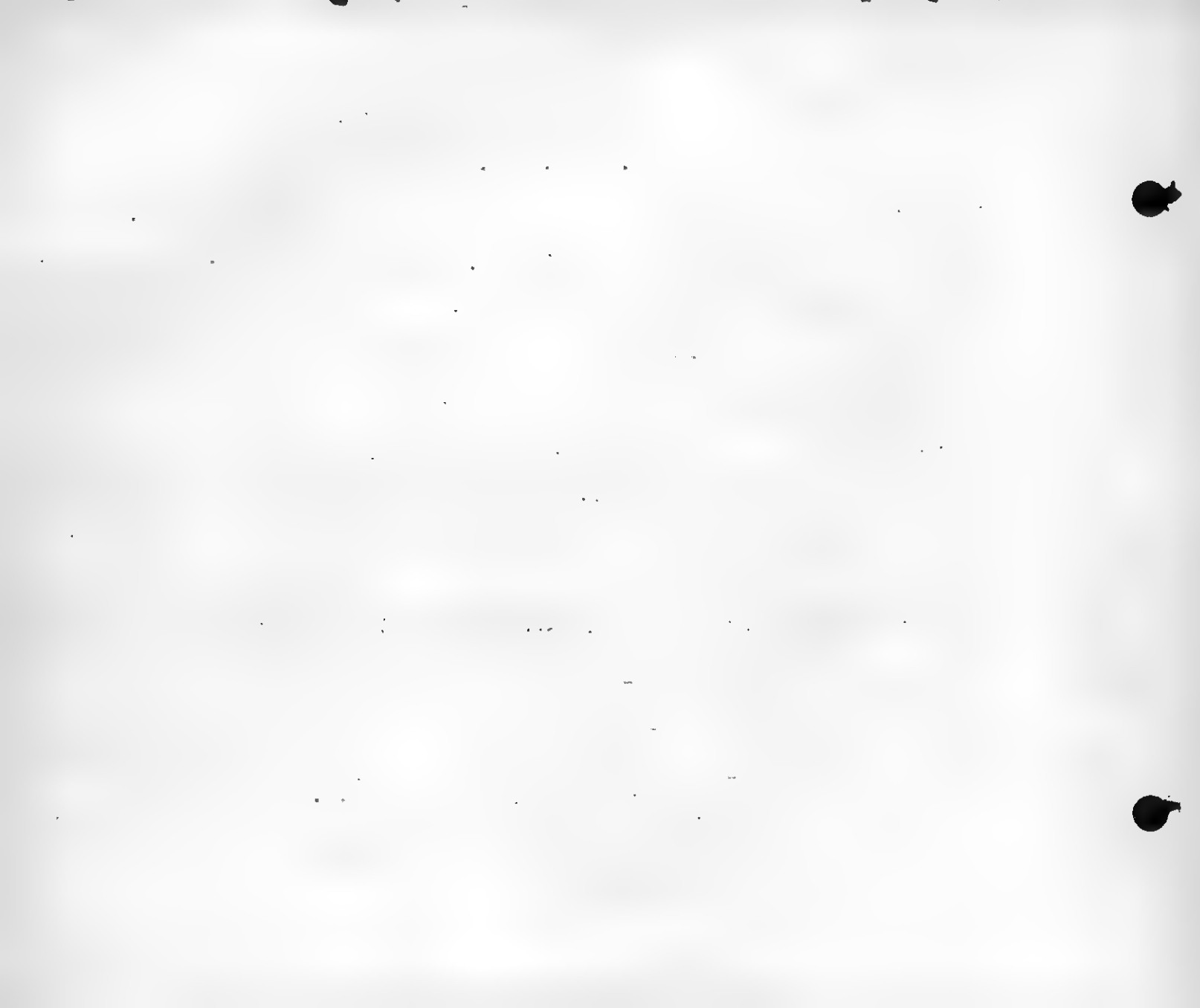
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 9yr. 11mo. 4da. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 641 Silver Spring Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) Herbert William Priestley			4. DATE OF DEATH Month 4 Day 25 Year 1966			5. SEX male		6. COLOR OR RACE white									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-8-85		9. AGE (In years last birthday) 80 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -- Building	
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William Priestley		14. MOTHER'S MAIDEN NAME Elizabeth Penophyl									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 579-07-1409		17. INFORMANT Hospital Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with psychotic reaction								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) --															
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) -- (County) (State)											
21. I certify that the this hospital attended the deceased from 5-21 , 19 56 , to 4-25 , 19 66 , that he we last saw the deceased alive on 4-25 , 19 66 , and that death occurred at 5-4-66 , from the causes and on the date stated above.																	
22a. SIGNATURE <i>Heard H. K. Klaatuh M.D.</i>				22b. DATE SIGNED 4-25-66		22c. PHYSICIAN'S NAME (Type) Dr. H. F. Klaatuh											
22d. ADDRESS Springfield State Hospital																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-66		23c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery		23d. LOCATION (City, town or county) Washington, D.C. (State)											
24. FUNERAL DIRECTOR <i>Harry Haight Sykesville, Md.</i>				25a. REC'D BY REGISTRAR MAY 2 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

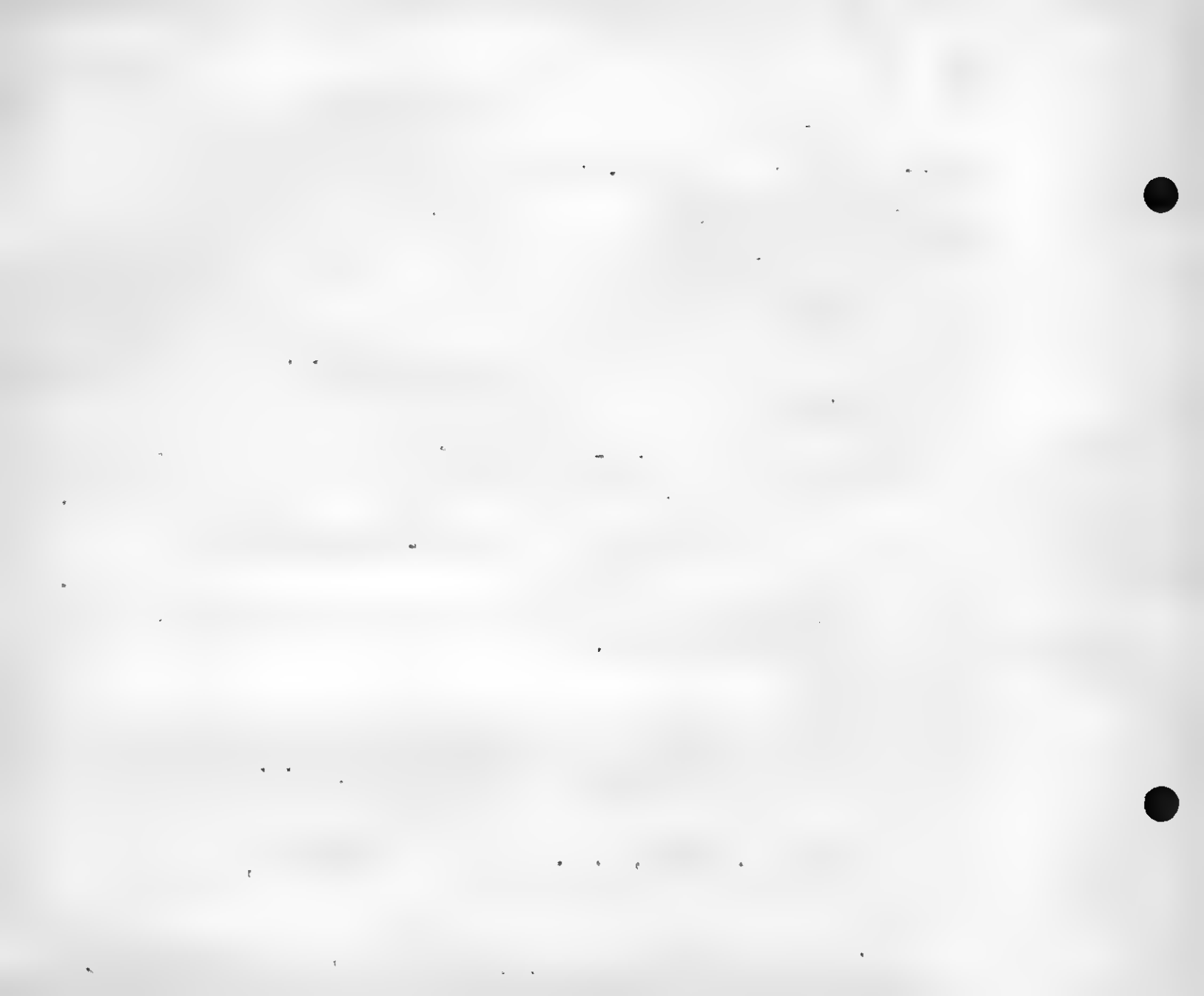
05137

05136

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) / a. STATE Maryland b. COUNTY Howard	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c LENGTH OF STAY IN lb 2mo. 7days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e STREET ADDRESS Route #1	
3 NAME OF DECEASED (Type or print) First Gladys Middle Ethel Last Ranlett		4 DATE OF DEATH Month 4 Day 25 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/15/90
9 AGE (In years last birthday) yrs 75		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Daniel Sullivan		14. MOTHER'S MAIDEN NAME unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 578-09-1290	
17 INFORMANT Springfield Hospital records-Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Occlusion of left coronary artery due to DUE TO (c) thrombosis		INTERVAL BETWEEN ONSET AND DEATH min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/18/ 19 66 to 4/25/ 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/25/ 19 66 , and that death occurred at 12:35 hr. from causes and on the date stated above.			
22a. SIGNATURE <i>Edmee J. Reeves</i>		22b DATE SIGNED 4/25/66	
22c PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/29/66	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR The S. H. Hines Company - Washington, D.C.		25a REC'D BY REGISTRAR APR 28 1966	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

05138

05137

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>				c. LENGTH OF STAY IN 1b <u>1 Month</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cranberry Road Rt. #4</u>				d. STREET ADDRESS <u>Snydersburg Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Dewey</u> Last <u>Rayner</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1898</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas D. Rayner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-235-3022</u>		17. INFORMANT <u>Christina Leptic-</u> Address <u>R-1 Brodbeck's, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Asthma + emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>5-10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>65</u> , to <u>4/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>66</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE <u>Donald A. Knight, MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Donald A. Knight, MD.</u>				22d. ADDRESS <u>Greenmount, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Finksburg Maryland</u>	
24. FUNERAL DIRECTOR <u>John E. Hoff</u>				ADDRESS <u>Hampstead, Md. 21074</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>APR 18 1966</u> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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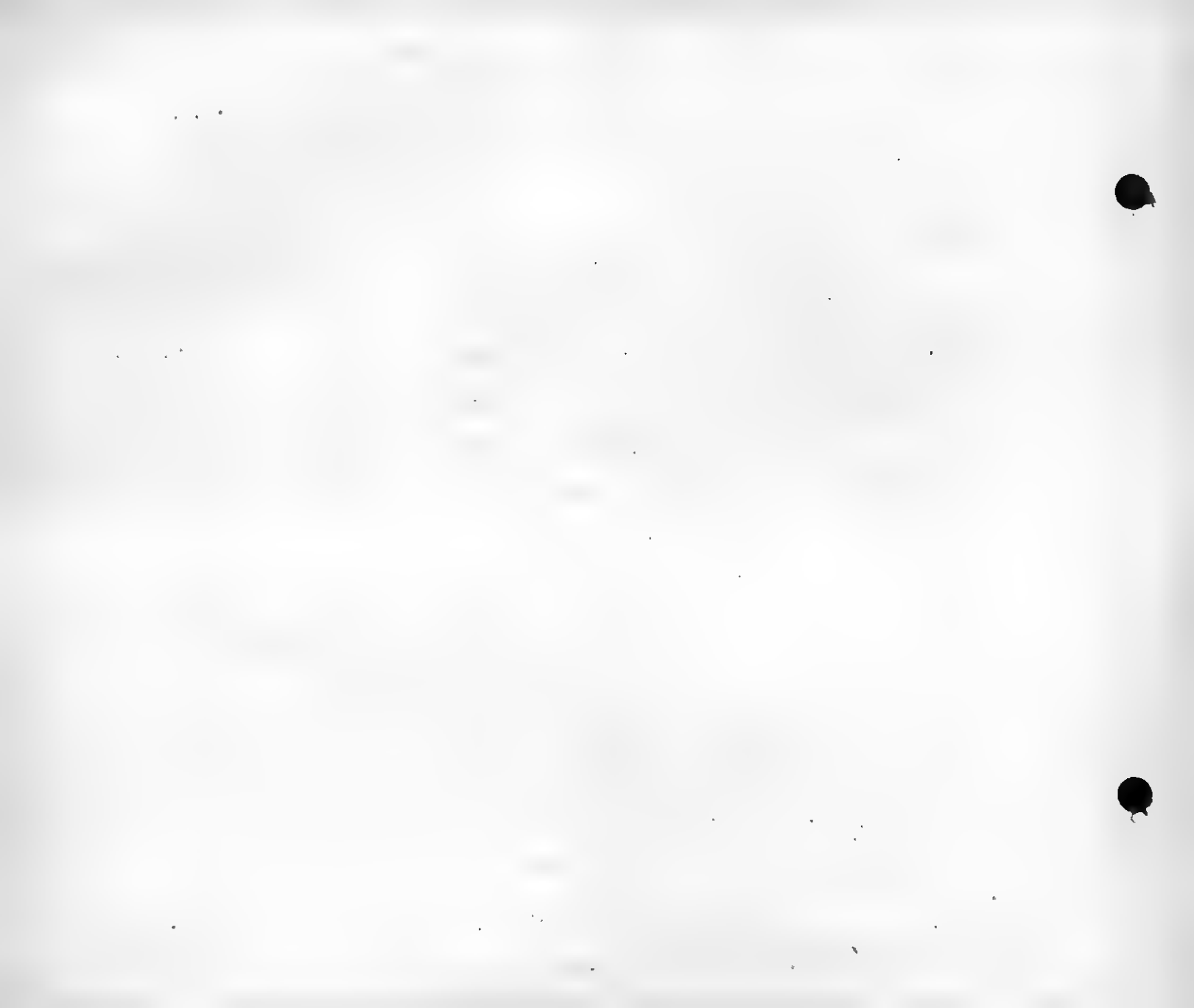
CERTIFICATE OF DEATH

Reg. Dist. No. 05138

05138

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 6 Wimert Avenue	
3 NAME OF DECEASED (Type or print) First George Middle Emerson Last Rue		4. DATE OF DEATH Month April Day 5 Year 1966	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1903
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR: Months 6 Days 15 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinery Operator		10b. KIND OF BUSINESS OR INDUSTRY Road building	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tilden W. Rue		14. MOTHER'S MAIDEN NAME Mary Etta Wroten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 218-09-0521	
17. INFORMANT Mrs. Marion Rue, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiectasis DUE TO 26x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic emphysema DUE TO Chronic Malnutrition (c) Chronic Malnutrition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/5 , 19 66 , to 4/5, 1966 , that I last saw the deceased alive on Never , 19 66 , and that death occurred at 7:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE William R O'Rourke M.D.		ADDRESS (Street, city or town, state) 150 W. Main St. Westminster, Md.	
PHYSICIAN'S NAME (Type) William R O'Rourke		DATE SIGNED 4-5-66	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Apr. 7, 1966	Grace Reformed Cemetery	Taneytown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John H. Skiles		ADDRESS C.O. Fuss & Son, Taneytown, Md.	
24a. REC'D BY REGISTRAR APR 7 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05140

05139

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN ID 6 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 67 W. Green Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 67 W. Green Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First RALPH Middle WHITELEY Last SCOTT		4. DATE OF DEATH Month April Day 15 Year 1966											
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 21, 1892	9. AGE (in years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS. Days 73	Hours 73	Min. 73					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) structural designer		10b. KIND OF BUSINESS OR INDUSTRY structural designer		11. BIRTHPLACE (County & State, or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Whiteley Scott				14. MOTHER'S MAIDEN NAME Byella ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 152-07-1065		17. INFORMANT Mrs. Gladys M. Wimert		Address 67 W. Green St. Westminster, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Bronchial Carcinoma DUE TO (c) Arteriosclerotic Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, INTERVAL BETWEEN ONSET AND DEATH 1/66 to 4/14/66						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/17/63 , 19 63 , to 4/1 , 19 66 , that (I) (we) last saw the deceased alive on 4/1 , 19 66 , and that death occurred at 6:55 AM, from the causes and on the date stated above.													
22a. SIGNATURE William R. Crouke						22b. DATE SIGNED 4/11/66			22c. PHYSICIAN'S NAME (Type) WILLIAM R. CROUKE				
22d. ADDRESS Westminster, Md.						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS Westminster, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/17/66		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City, town or county) (State) Westminster, Maryland		23e. REC'D BY REGISTRAR APR 19 1966			23f. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 12yrs.2mos.26dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 804 Wellington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ODEN			First ODEN		Middle SHERIDAN		Last SHIPLEY		4. DATE OF DEATH Month APRIL Day 4 Year 19 66		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-13		9. AGE (in years last birthday) 53		IF UNDER 1 YEAR Months 5 Days 4 IF UNDER 24 HRS. Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic at Beth. Steel Co.				10b. KIND OF BUSINESS OR INDUSTRY Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas L. Shipley					14. MOTHER'S MAIDEN NAME Fannie Shoemaker						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-14-9331		17. INFORMANT Records, Springfield State Hospital Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Possible infected emboli from right ventricle DUE TO (c) wall PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with convulsive disorder, without qualifying phrase										INTERVAL BETWEEN ONSET AND DEATH Days Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1-8-54 to 4-4-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-4-66 , 19 66 , and that death occurred at 1:05 AM , from the causes and on the date stated above.											
22a. SIGNATURE Frances Reid Nabors					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/4/66				
22c. PHYSICIAN'S NAME (Type) Frances Reid Nabors, M. D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/7/66		23c. NAME OF CEMETERY OR CREMATORY Church of God Ce.,			23d. LOCATION (City, town or county) (State) Carrollton, Md.			
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.					ADDRESS 6009 Harford Rd.		25a. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

05142

05141

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN TB <u>9 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>37 E. GEORGE ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>37 E. GEORGE ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD IRVING SIES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 19 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 17 1898</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD PETER SIES</u>				14. MOTHER'S MAIDEN NAME <u>LAURA KATE BURGOON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-0331</u>		17. INFORMANT <u>MRS. MARY P. SIES</u> Address <u>WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 19 1966</u> to <u>APRIL 19 1966</u> and that death occurred <u>4:38 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel I. Welliver</u> M.D.				22b. DATE SIGNED <u>4-19-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>				22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER, MD.</u>			
23a. BURIAL <u>BURIAL</u>		23b. DATE THEREOF <u>4/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY WESTMINSTER, MD.</u>		23d. LOCATION (City, town or county) (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James C. Saffell Jr.</u>				25a. REC'D BY REGISTRAR <u>APR 20 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05143

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Inc</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>Bredbeck Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Meldon</u> Last <u>Simmons</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Simmons</u>						14. MOTHER'S MAIDEN NAME <u>Alice Spencer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>219-36-1014</u>		17. INFORMANT Address <u>Mrs John Simmons Hampstead, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177x</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 4-25</u> , 19 <u>66</u> , to <u>April 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-25</u> , 19 <u>66</u> , and that death occurred at <u>4:35</u> A.M., from the causes and on the date stated above.													
22a. SIGNATURE <u>M.C. Porterfield</u>						22b. DATE SIGNED <u>4-26-66</u>		22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>				22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>April 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hampstead Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline Funeral Home</u>						25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					b. COUNTY Baltimore City				
c. LENGTH OF STAY IN 1b 10 mos. 16 dys.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 8601 Gray Fox Rd. 5136 Preston Avenue				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last ISADORE (NMN) SINSKEY					4. DATE OF DEATH Month Day Year APRIL 6 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-15-1890		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Salesman - Associated Mutual Dept. Race Track		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert Sinskey					14. MOTHER'S MAIDEN NAME Sarah (last name unk.)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-01-5099 A		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4 + 6 X DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-20-65, 19 to 4-6-66, 19, that (I) (we) last saw the deceased alive on 4-6-66, 19, and that death occurred at 11:00 PM, from the causes and on the date stated above.									
22a. SIGNATURE Frances Reid Nabors					22b. DATE SIGNED 4-6-66				
22c. PHYSICIAN'S NAME (Type) Frances Reid Nabors, M. D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF April 8, 1966		23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship			23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc. 6010 Reisterstown Rd.					25a. REC'D BY REGISTRAR DATE APR 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
05144																			
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>					c. LENGTH OF STAY IN 1b <u>2 YRS - 10 MOS - 11 DYS.</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRINGFIELD STATE HOSPITAL</u>					d. STREET ADDRESS <u>906 W. 31ST STREET</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Goldie</u> First <u>NMN</u> Middle <u>SMITH</u> Last					4. DATE OF DEATH <u>APRIL</u> Month <u>17</u> Day <u>19</u> Year <u>66</u>														
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>WILLIAM F. MCKEE</u>					14. MOTHER'S MAIDEN NAME <u>AMELIA</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-24-9039</u>					17. INFORMANT <u>RECORDS, SPRINGFIELD STATE HOSPITAL</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - CHRONIC BRAIN SYNDROME WITH CEREBRAL ARTERIOSCLEROSIS WITH PSYCHOTIC REACTION.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6-8-63</u> , 19 <u>63</u> , to <u>4-17-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-17-66</u> , 19 <u>66</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Octavio A. Ruiz</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>4-17-66</u>					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz</u>					22d. ADDRESS <u>SPRINGFIELD STATE HOSPITAL</u> <u>SYKESVILLE, MARYLAND</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>4/20/66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>					23d. LOCATION (City, town or county) (State) <u>BALTO, MD.</u>				
24. FUNERAL DIRECTOR <u>Carl E. Chomicki</u>					ADDRESS <u>3617 Chestnut Ave</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>					25b. REGISTRAR'S SIGNATURE				
										OATE <u>APR 20 1966</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05146								05145	
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2yr. 6mos. 23dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JOHN Middle JACOB Last SNYDER			4. DATE OF DEATH Month April Day 20 Year 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-74		9. AGE (In years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Levy S. Snyder Unknown				14. MOTHER'S MAIDEN NAME Mary Jane Kesselring Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-0951-A		17. INFORMANT Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.									INTERVAL BETWEEN ONSET AND DEATH Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-27-63 , 19 63 to 4-20-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-20-66 , 19 66 , and that death occurred at 3:30 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Octavio A. Ruiz				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-20-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/66		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Silver Run, Md.			
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05147					05146						
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester, md</i>			c. LENGTH OF STAY IN 1b <i>2 day</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Old Haystack Rd. Balto Co. md</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Longview Home 128 N. Main</i>					d. STREET ADDRESS <i>Sonn Lane (no number)</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>—</i> Last <i>Sonn</i>			4. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>1966</i>								
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-9-1890</i> 1870	9. AGE (In years last birthday) <i>95</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Balto Co. Prince Georges md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				
13. FATHER'S NAME <i>Henry Sonn</i>					14. MOTHER'S MAIDEN NAME <i>Henrietta Hayes</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>217-46-2111</i>		17. INFORMANT Address <i>RL #1 Box 267</i> <i>Cinn. Davis (daughter) Manchester, md</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis</i> DUE TO (c) <i>—</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>unknown</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> , 19 <i>66</i> to <i>4-7</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>4-6</i> , 19 <i>66</i> and that death occurred at <i>4:30</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>M.C. Porterfield</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-8-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>					22d. ADDRESS <i>Hampstead, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4-11-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Co. md</i>				
24. FUNERAL DIRECTOR <i>Lassahn Gunn Home 7101 Balan Road</i>					ADDRESS <i>(36)</i>		25a. REC'D BY REGISTRAR <i>APR 12 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05148		05147									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keymar Rural 1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY</u> First <u>BOY</u> Middle <u>Stambaugh</u> Last			4. DATE OF DEATH <u>4</u> <u>12</u> <u>1966</u>			Month <u>4</u> Day <u>12</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/66</u>		9. AGE (In years last birthday) <u>0</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Larry STAMBAUGH</u>						14. MOTHER'S MAIDEN NAME <u>Mary F. BLACK</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INEDRMAN <u>Mary Stambaugh</u> Address <u>Keymar MD</u>			18. INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>In maturity (Birth wgt 11'8")</u> 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ABRuptio Placenta</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11:34</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>66</u> , to <u>4-12</u> , 19 <u>66</u> , that <u>MY</u> (we) last saw the deceased alive on <u>4-12</u> , 19 <u>66</u> , and that death occurred at <u>11:34</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Karl W Green</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/12/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>KARL W GREEN</u>						22d. ADDRESS <u>WESTMINSTER MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION</u>			23d. LOCATION (City, town or county) (State) <u>KEYSVILLE MO</u>				
24. FUNERAL DIRECTOR <u>DR Hartzler & Sons Union Bridge Md</u> ADDRESS						25a. REC'D BY REGISTRAR <u>APR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05148

Item 9 filed 5/2/66

5/2/66

05148

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barth</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sheltonville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Handallstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Health Home</u>		d. STREET ADDRESS <u>8406 Glenwood Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Stansbury</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>May</u> Day <u>7</u> Year <u>1886</u>
9a. AGE (In years last birthday) <u>80</u> yrs.		9b. IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard Baker</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Price</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>McRandolph Stansbury</u>		Address <u>8406 Glenwood Rd Handallstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Heart Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> , 19 <u>66</u> to <u>April 25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>66</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>UNMASTIN</u>		22d. ADDRESS <u>Handallstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Freedom Park</u>		23d. LOCATION (City, town or county) (State) <u>Barth Md</u>	
24. FUNERAL DIRECTOR <u>Young & Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>APR 28 1966</u>	

CERTIFICATE OF DEATH

05149

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c LENGTH OF STAY IN b 23yrs. 2mos. 6dys. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS Exact address unknown	
3 NAME OF DECEASED (Type or print) ETHEL SIMES STEINER		4 DATE DEATH APRIL 25 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR: Months 12 Days 25 Hours 19 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mulligan		14. MOTHER'S MAIDEN NAME Isabel Simes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-46-3747	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe bronchopneumonia DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 10:05 AM p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-19-43 , 19 to 4-25-66 , 19, that (I) (we) last saw the deceased alive on 4-25-66 , 19, and that death occurred at 10:05 AM , from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 4-25-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/27/1966	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE APR 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

05151

05150

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katharine Middle Mary Last STEPHENS		4. DATE OF DEATH Month April Day 24 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1878
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none - AT Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. McMahon - dec.		14. MOTHER'S MAIDEN NAME Katherine Wallace - dec. Jacksonville Florida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 213-54-1807	
17. INFORMANT Joseph L Stephens - 1315 Talbot Ave - Springfield State Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) heart failure. 4200 DUE TO (b) Arteriosclerotic heart disease with congestive DUE TO (c) Generalized arteriosclerosis.		INTERVA. BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-14-66 , 19__, to 4-24-66 , 19__, that (I) (we) last saw the deceased alive on 4-24-66 , 19__, and that death occurred at 3 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn, M.D.		22b. DATE SIGNED 4-24-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-27-66	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery - Baltimore, Md	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md		23e. REC'D BY/REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR Ellsworth Armacost - 4600 Liberty Heights Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the above pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05152					05151									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster c. LENGTH OF STAY IN MD 6 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Westminster, Md. R. D. 4					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster d. STREET ADDRESS Westminster, Md. R. D. 4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) GERTIE A. STONESIFER			4. DATE OF DEATH Month April Day 12 Year 1966		5. SEX F 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10/7/1896 9. AGE (in years last birthday) 69 IF UNDER 1 YEAR: Months 69 Days 69 Hours 69 Min. 69									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework			10b. KIND OF BUSINESS OR INDUSTRY The Family Home		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Stonesifer					14. MOTHER'S MAIDEN NAME Ellen Stonesifer									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-52-3477		17. INFORMANT Mrs. Mazie Zepp Westminster, Md. R.D.1									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident about 443x DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Viral pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 hr 50 min														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1964 to Apr 12, 1966 that (I) (we) last saw the deceased alive on Apr 11, 1966 and that death occurred at 4:00 PM from the causes and on the date stated above.														
22a. SIGNATURE E. Reese Wilkens M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) E. Reese Wilkens 22d. ADDRESS 15 Kemper Westminister Md 22b. DATE SIGNED 4-12-66														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/14/66		23c. NAME OF CEMETERY OR CREMATORY Bachmans Valley Cemetery		23d. LOCATION (City, town or county) (State) Bachmans Valley, Carroll Co., Md.							
24. FUNERAL DIRECTOR Richard A. Little, Littlestown PA					25a. REC'D BY REGISTRAR APR 14 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

051583

CERTIFICATE OF DEATH

05152

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 7 mos. 2 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 33 West Wilson Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle TICE Last STOUFFER				4. DATE OF DEATH Month April Day 5 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-1886	
9. AGE (In years last birthday) 79 yrs.		10. UNDER 1 YEAR Months 7		11. UNDER 24 HRS. Days 1		12. UNDER 24 HRS. Hours 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Sterling				14. MOTHER'S MAIDEN NAME Anna Newcomer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6176A		17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE AND CEREBRAL ARTERIOSCLEROSIS 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-3-65 , 19 19 to 4-5-66 , 19 19 , that (I) (we) last saw the deceased alive on 4-5-66 , 19 19 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				22b. DATE SIGNED 4-5-66			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/8/66		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City, town or county) (State) HAGERSTOWN, MD	
24. FUNERAL DIRECTOR W. T. Housh				25a. REC'D BY REGISTRAR APR 12 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

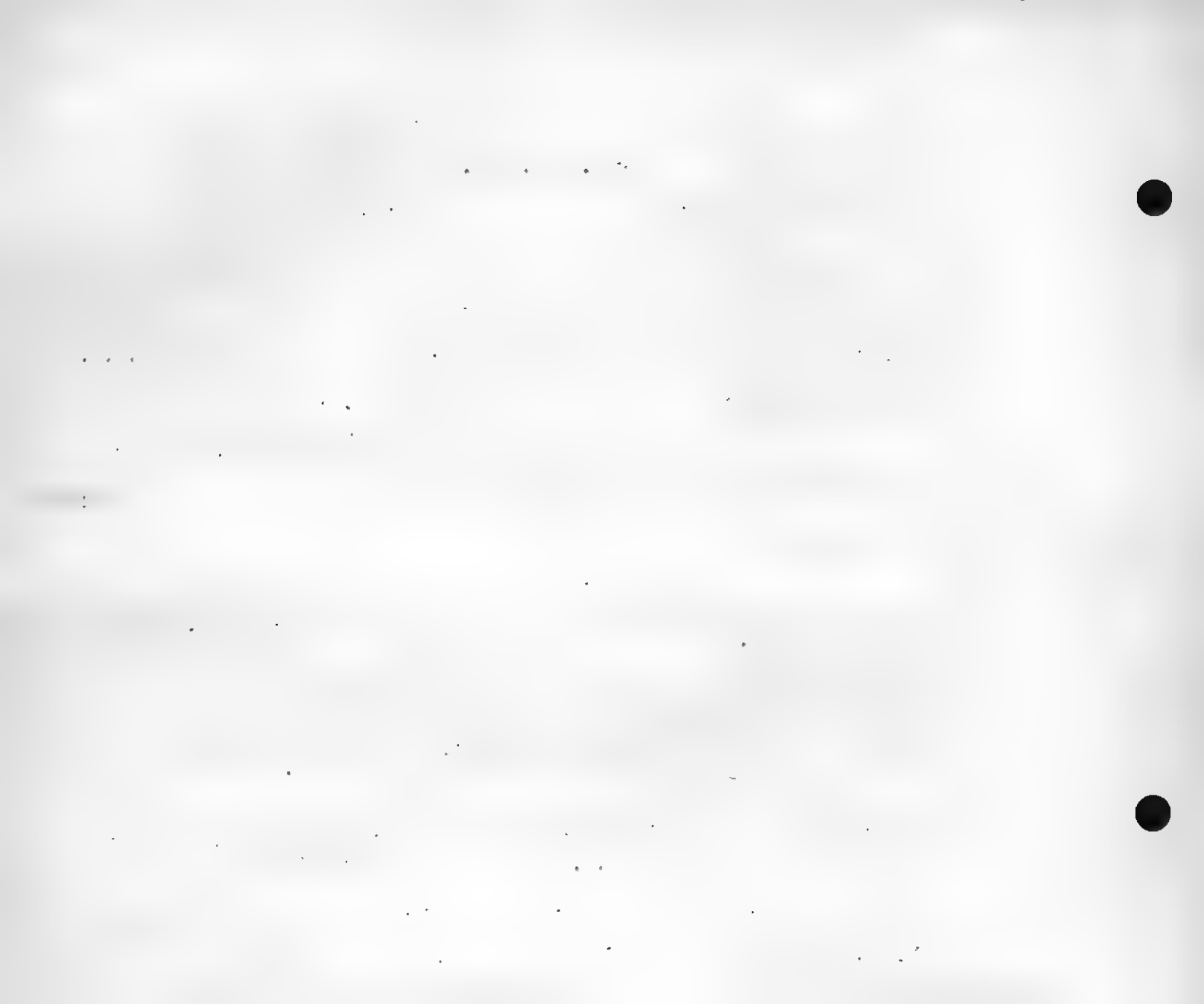
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05154					05153				
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 37yrs.6mos.26dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS (unknown)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle D. Last STREAKER			4. DATE OF DEATH Month APRIL Day 22 Year 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-09		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Streaker				14. MOTHER'S MAIDEN NAME Mary E. Donaldson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia in status epilepticus 3332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with convulsive disorder, without qualifying phrase.									INTERVAL BETWEEN ONSET AND DEATH Minutes to hours. Minutes
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from 9-26, 1928, to 4-22, 1966, that (1)-(we) last saw the deceased alive on 4-22, 1966, and that death occurred at A.M. from the causes and on the date stated above.									
22a. SIGNATURE Ilse Kamm, M.D.			22b. DATE SIGNED 4-22-66			22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.			
22d. ADDRESS Sykesville, Md.			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF April 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town or county) (State) Baltimore Co., Maryland		
24. FUNERAL DIRECTOR Burgess Funeral Home			ADDRESS 3631 Falls Road		25a. READ BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05155					05154				
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN ID 6 yrs. 4 mos. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1733 Terrell Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM (NMN) SYKES			4. DATE OF DEATH Month Day Year April 6 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-02		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Transportation			11. BIRTHPLACE (County & State, or foreign country) Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schellenberger					14. MOTHER'S MAIDEN NAME Mary E. Robinson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 217-03-9229		17. INFORMANT Miss Anna M. Hellman Address 3006 Weaver Ave Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis 44201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced pulmonary tuberculosis, active c) Chronic brain syndrome associated with brain trauma, gross force, with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with brain trauma, gross force, with psychotic reaction.								INTERVAL BETWEEN ONSET AND DEATH minutes years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-1-59 to 4-6-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-6-66 , 19 66 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Julian Radzykewycz M.O.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 4-6-66	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC BALTIMORE MD.					25a. REC'D BY REGISTRAR APR 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05156

05155

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 N Main St</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> d. STREET ADDRESS <u>1195 main St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gabriel VIRGINIA Thieret</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1876</u>		9. AGE (in years last birthday) <u>90</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Manchester, Md. (Carroll)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Valentine D. Manney</u>				14. MOTHER'S MAIDEN NAME <u>Hennietta Cremonese</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-036258</u>		17. INFORMANT <u>George Thieret (husband)</u> Address <u>1195 main St Manchester, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <u>Cerebral Arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>50</u> to <u>April 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1966</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W. H. Foward</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/24/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foward MD</u>				22d. ADDRESS <u>Manchester, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manchester Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 GILL AVE</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u> d. STREET ADDRESS <u>12 GILL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <u>METTIE BELLE TIPTON</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1965</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>July 4, 1881</u>			9. AGE (In years last birthday) <u>84</u> yrs. <table border="1"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months Days Hours Min.</td> <td>Months Days Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days Hours Min.	Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months Days Hours Min.	Months Days Hours Min.																
13. FATHER'S NAME <u>G Phillip Fuhrman</u>					14. MOTHER'S MAIDEN NAME <u>EMMA HOUCK</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-34-5754</u>		17. INFORMANT <u>Edward C Tipton</u>			Address <u>HAMPSTEAD, MD</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Arteriosclerotic Cerebrovascular disease</u> (c) <u>Hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>770X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____						
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1959</u> , to <u>April 25, 1966</u> , that (II) (we) last saw the deceased alive on <u>April 24, 1966</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Joseph E. Bush</u>										22b. DATE SIGNED <u>April 25, 1966</u>							
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>					22d. ADDRESS <u>HAMPSTEAD Maryland</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>			23d. LOCATION (City, town or county) <u>Hampstead, Md.</u>		(State) _____							
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home</u>					ADDRESS <u>Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05158

05157

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braunswick</u>	
c. LENGTH OF STAY IN ID. <u>3 yrs. 7 mo. 22 days</u>		d. STREET ADDRESS <u>302 - 9th Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mary</u> Last <u>Utterback</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel G. Hurst</u>		14. MOTHER'S MAIDEN NAME <u>Tacy Lanham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4. DUE TO (b) <u>Arteriosclerotic cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with cerebral arteriosclerosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>62</u> , to <u>4-16</u> , 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Suha Ozgun</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u>		22d. ADDRESS <u>Springfield State Hosp. Sikesville Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-17-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillsboro Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick VA.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 19 1966</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster c. LENGTH OF STAY in 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 82 E. Baltimore Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster d. STREET ADDRESS 82 E. Baltimore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) PAUL First VARNELL Last 4. DATE OF DEATH April 11 1966 Month Day Year					5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 21, 1925 9. AGE (in years last birthday) 40 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Kansas City, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Harvey Varnell 14. MOTHER'S MAIDEN NAME Bess Carroll				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --- (If yes give war or dates of service) --- 16. SOCIAL SECURITY NO. ? 17. INFORMANT Helen Maveric Varnell Address same					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound skull rt side 976x DUE TO Self Inflicted Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 1:30 a.m. 4-8-66 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work At Home 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westminster, Carroll 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22. DATE SIGNED 4-11-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S SIGNATURE W. Glenn Speicher M.D. Address 1355 E. Westminster, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE THEREOF April 11, 1966 23c. NAME OF CEMETERY OR CREMATORY Lafayette Cemetery 23d. LOCATION (City, town or county) (State) Brier Hill, Penna.					24. FUNERAL DIRECTOR J. E. Myers, Jr. Westminster, Md. ADDRESS 25a. REC'D BY REGISTRAR APR 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05160

05159

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAMPSTEAD c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle Z. Last WHEAT				4. DATE OF DEATH Month 4 Day 11 Year 1966							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1900		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wheat				14. MOTHER'S MAIDEN NAME Susan Baker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 214-03-7099				17. INFORMANT Mrs. Robert Utz, Hampstead, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septic ulcer, (ulcer)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 64 , to 12/11 , 19 65 , that (I) (we) last saw the deceased alive on 12/11 , 19 65 , and that death occurred at 12/11 , 19 65 , M, from the causes and on the date stated above.											
22a. SIGNATURE D. W. Wright				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) D. W. Wright			
22d. ADDRESS Hampstead, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/14/66		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City, town or county) (State) Finksburg Md.			
24. FUNERAL DIRECTOR Tipton-Eline				25. REG'D BY REGISTRAR APR 18 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05161

05161

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville RD#4 c. LENGTH OF STAY IN ID 8 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Near Sykesville				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville RD#4 d. STREET ADDRESS Near Sykesville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle DANIEL Last WHIPP				4. DATE OF DEATH Month April Day 20 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 March 1884	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (County & State, or foreign country) Adamstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME John N. Whipp				14. MOTHER'S MAIDEN NAME Maria Shellman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-2620		17. INFORMANT Mrs. Dora S. Whipp (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension, arteriosclerosis generalized DUE TO (c) cardiac failure							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 to 4-20 , 1966 , that (I) (we) last saw the deceased alive on 4-20 , 1966 , and that death occurred at 8 P M, from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall							
22b. DATE SIGNED 20 April 1966							
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22d. ADDRESS Sykesville, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-66		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05162

05161

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg RD #2 c. LENGTH OF STAY IN 1b 14 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg RD #2 d. STREET ADDRESS Box 410 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle Last WHITE			4. DATE OF DEATH Month April Day 28 Year 1966				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1917	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY Nat'l Dairies		11. BIRTHPLACE (County & State, or foreign country) Jeannette, Pa.			
13. FATHER'S NAME William White			14. MOTHER'S MAIDEN NAME Nora McCarthy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 209-09-3388		17. INFORMANT Mrs. Beatrice V. White Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Angina Pectoris DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 5 min. 2 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 1-7-55 , 19__, to 4-28-66 , 19__, that (I) (we) last saw the deceased alive on Apr. 28 , 19 66 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
22a. SIGNATURE D. D. Caples			22b. DATE SIGNED 4-28-66				
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/2/66		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens			
				23d. LOCATION (City, town or county) (State) Finksburg, Md.			
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.			25a. REC'D BY REGISTRAR MAY 2 1966				
			25b. REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05163

05162

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 3 mos. 26 dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS 305 Commercial Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES First WILLIAM Middle WHITEHEAD Last		4. DATE OF DEATH April Month 20 Day 19 Year 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-20-09		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Julius C. Whitehead		14. MOTHER'S MAIDEN NAME Clara M. Waskey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1941-1942		17. INFORMANT Records, Springfield State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA OF LEFT TONSIL WITH NECK METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-24-65 , 19 65 to 4-20-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-20-66 , 19 66 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Octavio A. Ruiz		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-20-66			
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-66		23c. NAME OF CEMETERY OR CREMATORY Savage Cem			
23d. LOCATION (City, town or county) Savage Md.		23e. (State) Md.		24. FUNERAL DIRECTOR William A. ...			
24. ADDRESS		25a. REC'D BY REGISTRAR APR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

05164

05163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mary Belle Zarger			4. DATE OF DEATH Month Day Year 4 17 19 66		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/10/86		9. AGE (In years at birthday) yrs. 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland--Artemas, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Simon Clingerman		
14. MOTHER'S MAIDEN NAME Eliza Leasere			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Springfield Hospital records--Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure due to myocardial infarction days DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Chronic bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 4/4/ , 19 66 , to 4/17/ , 19 66 , that we (we) last saw the deceased alive on 4/17/ , 19 66 , and that death occurred at 11:30 P. M, from causes and on the date stated above.					
22a. SIGNATURE <i>Maneeratana Fuangvudhiran</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/17/66	
22c. PHYSICIAN'S NAME (Type) Maneeratana Fuangvudhiran, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 21, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 20 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>05165</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>05164</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY CARROLL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL Sykesville				c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R Sykesville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Linger Nursing Home						d. STREET ADDRESS Springfield Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick W. Middle Zimmerman Last 						4. DATE OF DEATH Month April Day 25 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-1886		9. AGE (in years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Zachary Zimmerman						14. MOTHER'S MAIDEN NAME Annie C. Baer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 7		17. INFORMANT Address Mrs. Nellie Zimmerman - Sykesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4342 DUE TO (b) Paricula fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cardiac Asthena PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Infection. Generalized Arteriosclerosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 26, 1965 to APR 25, 1966 , that (I) (we) last saw the deceased alive on APR 25, 1966 , and that death occurred at 1:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Sani Okutman						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4.26.1966			
22c. PHYSICIAN'S NAME (Type) Sani Okutman						22d. ADDRESS Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-28-66		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW Cemetery				23d. LOCATION (City, town or county) (State) Sykesville, Md.			
24. FUNERAL DIRECTOR Harry W. Haight						ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR MAY 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

10430

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